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Issue Date: 23 August 2004

Case No. 2000-BLA-00727

BRB No. 97-1262 BLA

In the Matter of

SAMMY JOE MAYNARD,
Claimant
v.

EASTERN COAL COMPANY,
Employer

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party In Interest

APPEARANCES:
Leonard Stayton, Esquire, for the Claimant
Lois A. Kitts, Esquire, for the Employer
James M. Kennedy, Esquire, for the Employer

BEFORE: RICHARD E. HUDDLESTON
Administrative Law Judge

DECISION AND ORDER ON REMAND—AWARDING BENEFITS

This proceeding arises from a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972, and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. §901 *et seq*. (hereinafter referred to as the Act). This case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs, for a formal hearing. Benefits are provided under the Act to a miner who is totally disabled due to pneumoconiosis and to certain survivors of a miner who died due to or while totally (or in certain cases, partially) disabled by pneumoconiosis. Pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

This case has a lengthy procedural history dating back more than seventeen years. The Claimant, Sammy Joe Maynard, filed a claim for black lung benefits on April 6, 1987. (DX 1).[1]

[1] CX-Claimant's exhibits; EX-Employer's exhibits; DX-Director's exhibits; D&O #1-Administrative Law Judge Decision and Order Awarding Benefits dated July 2, 1993 (Case No. 1990-BLA-2109); D&O #2-Administrative

On September 15, 1987, and December 17, 1987, the application was denied by the District Director, Office of Workers' Compensation Programs. (DX 29, 40). Claimant requested a formal hearing, and the case was forwarded to the Office of Administrative Law Judges. (DX 41). The case was remanded to the District Director pending the outcome of Claimant's state workers' compensation claim, and the Director again denied the claim on March 28, 1990. (DX 42, at 2, 67-69). Claimant requested a formal hearing, and the case was forwarded to the Office of Administrative Law Judges on June 26, 1990. (DX 43).

A formal hearing was scheduled for June 13, 1991, in Prestonsburg, Kentucky, but upon commencement of the hearing the parties agreed to a decision on the record. The record was identified as Director's Exhibits Nos. 1 through 43 (DX 1 - DX 43); Claimant's Exhibit No. 1 (CX 1); and Employer's Exhibits Nos. 1 through 8 (EX 1 - EX 8). On July 2, 1993, I issued a Decision and Order Awarding Benefits.[2] On July 26, 1993, Employer appealed the decision to the Benefits Review Board. On February 22, 1995, the Benefits Review Board vacated the decision and remanded the case for reconsideration of the X-ray evidence under §718.202(a)(1) in light of *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). The Board also directed reconsideration of all the X-ray evidence and the evidence of complicated pneumoconiosis pursuant to §718.304, and whether Claimant could establish total disability under Part 718.

The parties were permitted to submit briefs regarding the issues to be considered on remand. After reconsideration of all of the X-ray evidence, I issued a second Decision and Order Awarding Benefits on May 12, 1997.[3] In that decision, I found that the X-ray evidence established the presence of pneumoconiosis pursuant to §718.202(a)(1); that Claimant was entitled to the rebuttable presumption that his pneumoconiosis arose out of his coal mine employment under §718.203(b); that no evidence was presented to rebut this presumption; and that Claimant established that his pneumoconiosis arose from his coal mine employment. (D&O #2, at 9). I also found that there were no qualifying pulmonary function studies or arterial blood gas studies, nor is there evidence of cor pulmonale with right-sided congestive heart failure. 29 C.F.R. §718.204(c)(1-3). There were no physicians who found that Claimant could not perform his usual coal mine employment from a respiratory standpoint. *Id*. §718.204(c)(4). (D&O #2, at 9-10). Finally, I found that the evidence was sufficient to establish that Claimant had complicated pneumoconiosis as permitted under §718.304, and that it was therefore presumed that Claimant was totally disabled due to pneumoconiosis and was entitled to black lung benefits, with an onset date of October 26, 1985. (D&O #2, at 10).

On June 6, 1997, Employer appealed the second Decision and Order Awarding Benefits. On May 20, 1998, the Benefits Review Board affirmed in part and vacated in part the decision and remanded the case a second time for further consideration. Specifically, the Board affirmed

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Law Judge Decision and Order Awarding Benefits dated May 12, 1997 (Case No. 1990-BLA-2109); BRB #1-Benefits Review Board Decision and Order dated February 22, 1995 (BRB No. 93-2104 BLA); BRB #2-Benefits Review Board Decision and Order dated May 20, 1998 (BRB No. 97-1262 BLA).

[2] The Decision and Order Awarding Benefits issued on July 2, 1993, was issued under Case Number 1990-BLA-2109, which was the case number assigned prior to the case being remanded to the District Director, OWCP, on September 30, 1999.

[3] This Decision and Order Awarding Benefits was issued under Case Number 1990-BLA-2109.

the findings from the second Decision and Order Awarding Benefits regarding the length of coal mine employment (13-1/3 years); the onset date of total disability; and the findings pursuant to §718.203(b) ; and the findings pursuant to §718.204(c)(3-4). (BRB #2, at 2 fn.2).

The Board vacated the finding of complicated pneumoconiosis under Section 718.304, and instructed that all relevant evidence should be considered and that an "adequate rationale for crediting or discrediting this evidence" be provided. The Board also instructed that additional comments included on the X-ray forms that may call into question a physician's diagnosis of complicated pneumoconiosis be considered, specifically those notations on the X-ray readings of Drs. Kennard, Fisher, Bassali, and Ameji. The Board also found that "the record contains numerous medical opinions in which none of the physicians diagnosed complicated pneumoconiosis and several noted possible tuberculosis or sarcoidosis," and instructed that this medical opinion evidence be considered on remand. (BRB #2, at 3-4). The Board also found that error was committed in considering the pulmonary function and blood gas studies to support the conclusion that Claimant had established complicated pneumoconiosis to the extent that, without accompanying explanation, the evidence was not relevant in establishing the existence of complicated pneumoconiosis. To this extent, the Board also noted that "the evidence is insufficient to demonstrate total respiratory disability pursuant to Sections 718.204(c)(1) and (2) [] inasmuch as none of the pulmonary function or blood gas studies yielded qualifying values." (BRB #2, at 3-4 and fn.5). Finally, the Board instructed that the undersigned must "first... evaluate the evidence in each category and then weigh the contrary evidence from Section 718.304(a)-(c) [] together to determine whether invocation is established." (BRB #2, at 4).

On August 5, 1998, I issued an order permitting the parties to submit briefs regarding the issues to be considered on remand. After examining the record, including the briefs submitted by the parties as to the issues to be considered on remand, I determined that, in view of the Board's findings, the record was incomplete as to the issues of whether Claimant had complicated pneumoconiosis and whether he had ever suffered from tuberculosis or sarcoidosis. At that point, the most recent medical evidence in the record was fourteen years old and did not reflect Claimant's current medical condition. I also found that, because a formal hearing was never conducted, relevant facts needed to be developed, including whether Claimant was ever diagnosed with or treated for tuberculosis or sarcoidosis. Therefore, pursuant to 20 C.F.R. §725.456(e), I remanded the matter to the office of the District Director, OWCP, for further development of evidence. I ordered the District Director to provide a complete pulmonary examination with appropriate diagnostic testing. I also permitted the parties to submit additional medical evidence addressing the issues of whether Claimant had a totally disabling pulmonary disease arising out of his coal mine employment, whether he suffered from tuberculosis, sarcoidosis, or any other lung condition. I also ordered Claimant to submit to a new medical examination by a physician of Employer's choosing, if Employer so desired.

This case was returned to this office for a formal hearing on May 10, 2000. On September 27, 2000, an order issued summarizing that the parties agreed that a hearing was not necessary and that a decision on the record could be issued. The order also held the record open for 90 days for the submission of evidence by the parties and an additional 30 days thereafter for the submission of briefs.

During the time period in which the parties were permitted to submit briefs, the Department of Labor amended the black lung regulations on December 20, 2000, with an effective date of January 19, 2001. These amendments were to 20 C.F.R. Part 718 and were to apply to the adjudication of all pending black lung claims. *See* 20 C.F.R. §718.2 (2001). With limited exceptions, the amendments to Part 725 of the regulations were to apply to claims filed after January 19, 2001. *See* 20 C.F.R. §725.2 (2001).

A controversy ensued in the Federal courts regarding the application of the amendments to the black lung regulations. A preliminary injunction was sought in the United States District Court for the District of Columbia by the National Mining Association (which is not a party in the instant matter) to enjoin implementation of certain provisions of the amended regulations. On February 9, 2001, United States District Court Judge Emmet G. Sullivan issued a Preliminary Injunction Order. *Nat'l Mining Ass'n v. Chao*, 160 F.Supp. 2d 47, 53 (D.D.C. 2001). Paragraph 3 of the court's order required that all pending black lung proceedings before the Office of Administrative Law Judges be stayed "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case." In light of the Preliminary Injunction, counsel for Employer requested that the instant matter be held in abeyance. On March 2, 2001, counsel for Claimant filed a brief arguing that the new regulations were applicable to the instant claim, but that the case should not be delayed as the new regulations do not impact upon the question of whether Claimant has complicated pneumoconiosis. I issued an order on March 12, 2001, which directed Employer to submit a brief within ten days of this order stating with specificity how application of the amended regulatory provisions would affect the outcome of this claim. The order also held the matter in abeyance until the applicability of the new regulations could be determined.

The United States District Court for the District of Columbia issued a decision on August 9, 2001, finding that the regulations, as amended, were valid, and therefore, the preliminary injunction was dissolved. *Nat'l Mining Ass'n v. Chao*, 160 F.Supp. 2d 47 (D.D.C. 2001). As a result of this decision, the substantive medical criteria in the new Part 718 applies to this case. In an order issued August 10, 2001, I directed that the parties submit their arguments as to how they wished to proceed in the matter in light of the holding of the U.S. District Court. Employer's counsel responded by requesting that the case be remanded to the District Director, or alternatively, to reopen the record for the submission of additional evidence in light of the changed standards. In an order issued on August 21, 2001, I denied Employer's request to remand the case, but granted the request to reopen the record. The parties were permitted 30 days to submit evidence addressing the new regulatory standards applicable to this case, and 60 days to submit briefs.

A telephone conference between counsel for the parties and the undersigned was held on September 7, 2001, and an order was issued on that date reopening the record for 90 days from the date for the development of additional medical evidence on the issues of whether Claimant has or has ever had tuberculosis, sarcoidosis, histoplasmosis, or emphysema, and for the submission of briefs within 120 days. Subsequent orders granting extensions of time for the development of evidence were issued on December 7, 2001; January 29, 2002; March 15, 2002; and May 23, 2002.

On May 23, 2003, an order was issued closing the record. On June 9, 2003, counsel for Claimant filed a Motion for Reconsideration, seeking additional time to determine if additional medical evidence needed to be developed. By order dated June 13, 2003, Claimant was granted an additional fifteen days to determine if he needed additional time to develop medical evidence. On July 2, 2003, I issued an order holding the record open to permit the deposition of Dr. Younes, which was scheduled to take place on October 8, 2003. The record was held open until November 8, 2003, for the submission of Dr. Younes' deposition, and the parties were allowed until December 1, 2003, to submit their respective arguments. An extension of time to take the deposition of Dr. Younes was granted by order issued on October 17, 2003, and a subsequent extension was granted on October 30, 2003, which held the record open until February 7, 2004, for the submission of Dr. Younes' deposition.

By order issued January 21, 2004, a final extension of time was granted, and the parties were permitted until March 11, 2004, to submit their evidence. The record was closed by order issued April 5, 2004, and the parties were directed to file their briefs by May 7, 2004. Both parties have now submitted their briefs.

The findings of fact and conclusions of law which follow are based upon an analysis of the record, including all documentary evidence provided, statutory provisions, regulations, case law, and arguments of the parties.

ISSUES

The issues presented on remand are:

1. Consideration of additional comments contained on the X-ray readings of Drs. Kennard, Fisher, Bassali, and Ameji regarding whether Claimant has complicated pneumoconiosis;

2. Consideration of medical opinions in which there was not a diagnosis of complicated pneumoconiosis and but there was a notation of possible tuberculosis or sarcoidosis;

3. Consideration of the pulmonary function and blood gas studies and whether those studies provide relevant evidence as to whether Claimant has established the existence complicated pneumoconiosis;

4. Consideration of the proper weight to assign to all of the relevant evidence of record and the rationale for crediting or discrediting this evidence; and

5. Determination of whether Claimant has established the existence of complicated pneumoconiosis and thus is totally disabled.

MEDICAL EVIDENCE

The following medical evidence has been submitted in connection with this claim.

X-Rays:

Date	Exhibit	Physician/ Qualifications[4]	Interpretation for Pneumoconiosis
01 21 1981	DX 13, p. 4	Levy	Film quality not stated; 0/0; Normal Chest
07 10 1984	DX 14, p. 14 DX 36	Srisumrid, BCR	Film quality not stated; No active lung infiltrates or tumor or pleural effusion. Mild degree of radiating fibrotic scars from both hilar to the upper lobes bilaterally.
10 26 1985	DX 17	Anderson	Film quality 2; 0/0
10 26 1985	DX 37, p. 14	Kennard, B/BCR	Film quality 1; 1/0 q/q, 4 upper zones; Cat. A large opacities, previous surgery, vascular clips at cardia
10 26 1985	DX 37, p. 13	Fisher, B/BCR	Film quality 1; 2/1 p/t, 4 upper zones; Cat. A large opacities; ax, co, hi, tb
10 26 1985	DX 37, p. 17	Brandon, B/BCR	Film quality 2; 1/0, p/t, 2 upper zones
10 26 1985	DX 37, p. 11 DX 42, p. 57	Cole, B/BCR	Film quality 2; 1/1 q/t, upper 4 zones; ax (coalescence of pneumoconiotic opacities); c.w.p. Category 1, surgical clips upper abdomen.
10 26 1985	DX 37, p. 12 DX 42, p. 56	Marshall, B/BCR	Film quality 1; 1/0 p/p; 3 zones; no large opacities
10 26 1985	DX 37, pp.7, 8 DX 42, p. 60	Bassali, B/BCR	Film quality 1; 1/1 q/t, Cat. A large opacity, complicated pneumoconiosis, upper and middle zones; diffuse chronic interstitial lung disease consistent with pneumoconiosis; distortion of the intrathoracic structures with elevation of both hila; di; tb; rule out active tuberculosis.
10 26 1985	DX 37, p. 5 DX 42, p. 64	Mathur, B/BCR	Film quality 1; 1/2 p/s, 6 zones; emphysema
10 26 1985	DX 76, pp. 85,88	Broudy, B/BCR	Film quality 2; scarring in both apices with some elevation of the hilar structures; negative for pneumoconiosis, possible healed granulomatous disease, scattered calcifications
10 26 1985	DX 42, p. 55	Ameji	Film quality 1; 2/1, p/t; 4 zones; Cat. A; ax, co, hi, tb
10 26 1985	EX 11	Sargent, B/BCR	Film quality not stated; s/t 0/1 in the upper and middle lung zones; the appearance is more that of a previous granulomatous disease such as old tuberculosis, histoplasmosis, or even sarcoidosis.

[4] In this decision, "B" refers to B reader, "BCR" refers to Board Certified Radiologist, and "BER" refers to Board Eligible Radiologist. The physicians' qualifications were obtained either from the record or judicial notice has been taken of the current National Institute for Occupational Safety and Health, Division of Respiratory Disease Studies List of Certified Roentgenographic Interpreting Physicians "B" Readers, and the American Medical Dictionary, Physicians in the United States. Any party wishing to prove the contrary of any fact so noticed may do so by filing a request for reconsideration in accordance with 20 C.F.R. §725.479(b).

Date	Exhibit	Physician/ Qualifications[4]	Interpretation for Pneumoconiosis
10 26 1985	DX 42, p. 18	Aycoth, B/BCR	Film quality not stated; 2/2 p/q, Cat. A. complicated pneumoconiosis; scattered rounded opacities measuring from 1.5 to 3 mm in diameter throughout both lung zones with two and possibly three 1 cm. ill-defined rounded density opacities of the apical lung zones. Lungs are well aerated and free of active disease.
10 26 1985	DX 46 CX 1	Wright	Film quality not stated; 1/0 q of the middle and upper zones; possibility of TB in left upper zone.
10 26 1985	DX 37, p. 9 DX 42, p. 59	Marshall, B/BCR	Film quality 2; 1/1 p/q, 6 zones
10 26 1985	DX 37, p. 4 DX 42, p. 63	Robinette, B	Film quality 1; 1/1 q/p, 4 upper zones; bilateral upper lobe reticular nodular infiltrate consistent with cwp with perfusion of 1/1 q with axillary coalescence.
10 26 1985	DX 42, pp. 17, 19, 66	Jakobson, BCR	Film quality not stated; 1/1 t/r both upper lung fields - Other etiologies to consider would be TB. Questionable mass in the aortic pulmonary window which may represent CA (cancer) or possibly enlarged central pulmonary artery.
10 26 1985	EX 9, p.15	Rosenberg, B	Film quality 2 (light film); negative for pneumoconiosis; di; hi; streaky infiltrates upper lobes; no background changes of pneumoconiosis otherwise; film could be "recorded" as having parenchymal abnormalities out of context with known clinical history
10 26 1985	DX 37, pp. 6,10 DX 42, p. 58	Deardorff, B/BCR	Film quality 2; 1/1 s/t; upper two zones, (ax)=4x20mm coalescence of small opacities left 2nd interspace. Marked loss in volume of upper lobes could have resulted from TB, but no typical calcification of TB; therefore, believes that the findings result from pneumoconiosis. Films show less than optimum contrast and there are processing artifacts - x-rays are quite readable.
10 26 1985	EX 14, p. 7	Repsher, B	Film quality 1; negative for pneumoconiosis; em; Biapical granulomatous disease of unclear activity.
10 26 1985	DX 37, p. 16	KHA (reader indicates he is a B reader but gave initials only)	Film quality 2; 1/1 q/q, 2 upper zones; Cat. A Large Opacities
05 14 1986	DX 14 DX 36	Srisumrid, BCR	Film quality not stated; No active lung infiltrates or tumor or pleural effusion.
12 01 1986	DX 76, pp. 89,86	Broudy, B/BCR	Film quality 1; negative for pneumoconiosis, possible healed granulomatous disease, scattered calcifications most likely due to tuberculosis or histoplasmosis
12 01 1986	DX 50 (EX 6)	Halbert, B/BCR	Film quality 1; chronic appearing infiltrates present in the upper lung zones bilaterally, which are producing distortion of the hilar structures bilaterally; No pneumoconiosis; probable old granulomatous disease.

Date	Exhibit	Physician/ Qualifications[4]	Interpretation for Pneumoconiosis
12 01 1986	DX 50 (EX 7)	Kim, B/BCR	Film quality 1; No pneumoconiosis; Chronic linear fibrotic change at both upper lobes.
12 01 1986	DX 51 (EX 8)	Poulos, B/BCR	Film quality 1; Retraction of both hilar areas superiorly by chronic appearing interstitial changes noted in both upper lung fields. No pneumoconiosis; probable old granulomatous disease.
12 01 1986	DX 20	Cooper	Film quality not stated; 1/2; lung fields consistent with pneumoconiosis.
12 01 1986	EX 9, p. 14	Rosenberg, B	Film quality 1; negative for pneumoconiosis; di; hi; Progression of streaky upper lobe infiltrates; Pleural based density R upper lobe; film could be "recorded" as having parenchymal abnormalities out of context with known clinical history.
12 01 1986	EX 14, p. 8	Repsher, B	Film quality 1; negative for pneumoconiosis; em; tb; Biapical progressive granulomatous disease.
01 19 1987	DX 16	Harrison, B	Film quality good; Abnormal; hilar adenopathy; numerous small, rounded, and irregular opacities which appear to be coalescint. Could not rule out coal workers pneumoconiosis; felt that Claimant should undergo pulmonary evaluation.
02 18 1987	DX 76, pp. 90, 86	Broudy, B/BCR	Film quality 1; negative for pneumoconiosis, possible healed granulomatous disease, scattered calcifications
02 18 1987	DX 42, p. 53	Spitz, B/BCR	Film quality good; 1/1 q/t; Findings could also be caused by tuberculosis; possibly a large opacity on the right and possibly a slightly smaller one on the left-approximately. It is important to obtain history of tb or at least check for tb at this time
02 18 1987	DX 15,20A,27	Broudy, B/BCR	Film quality 1; No pneumoconiosis
02 18 1987	EX 9, p.13	Rosenberg, B	Film quality 1; negative for pneumoconiosis; di; hi; upper lobe streaky infiltrates; pleural based density R upper lobe; film could be "recorded" as having parencylmal abnormalities out of context with known clinical history.
02 18 1987	EX 14, p. 9	Repsher, B	Film quality: unreadable (dark).
05 07 1987	DX 28 DX 37, p. 15	Poulos, B/BCR	Film quality 1; 1/1, q/q, upper 4 zones
05 07 1987	DX 38, 39	Wiot, B/BCR	Unreadable film quality
05 07 1987	DX 37, pp. 18,19 DX 42, p. 54	Felson, B/BCR	Film quality 1; 2/1 p/t; 3 zones; Cat. A large opacities, probable pneumoconiosis, although sarcoidosis is not excluded; di (marked distortion of the intrathoracic organs).
05 07 1987	DX 26	Sargent, B/BCR	Film quality 1; 1/1 t/q, 3 zones (2 upper, 1 mid); scoliosis; widened aorta
05 07 1987	DX 22 DX 42, p. 61	Mettu	Film quality not stated; 1/1 q/q; small rounded opacities in mid and upper lung fields.

Date	Exhibit	Physician/ Qualifications[4]	Interpretation for Pneumoconiosis
08 06 1987	EX 9, p.12	Rosenberg, B	Film quality 1; negative for pneumoconiosis; di; hi; more prominence of streaky infiltrates in R upper lobe; film could be "recorded" as having parenchymal abnormalities out of context with known clinical history.
08 06 1987	DX 42, p. 62	Wiot, B/BCR	Film quality good; 1/2 q/t, upper lobes, ax, coalescence of pneumoconiotic nodules in the left apex
08 06 1987	DX 37, p. 3 DX 42, p. 65	Lane, B	Film quality 1; 1/0 q/p, upper 4 zones; emphysema, tuberculosis
08 06 1987	DX 76, pp. 91,86	Broudy, B/BCR	Film quality 1; negative for pneumoconiosis, possible healed granulomatous disease, scattered calcifications
08 06 1987	EX 14, p. 10	Repsher, B	Film quality 1; negative for pneumoconiosis; em; tb; Biapical granulomatous disease.
04 27 1991	EX 9, p. 11	Rosenberg, B	Film quality 1; negative for pneumoconiosis; loss of volume in upper lobe continues; nodularity of pleural based density (RUL) more obvious; streaky densities more coalescent; film could be recorded as having parenchymal abnormalities out of context with known clinical history
04 27 1991	DX 47 (EX 4)	Scott, B/BCR	Film quality 1; No pneumo. Probable fibrosis apices with hilar elevation compatible with healed TB. No evidence of silicosis or coal workers' pneumoconiosis.
04 27 1991	DX 47 (EX 3)	Wheeler, B/BCR	Film quality 1; No pneumo. Moderate linear fibrosis upper portion both upper lobes and elevation hila compatible with probable radiation therapy for Hodgkins or possible healed TB. Hyperinflation of lungs from deep breath or emphysema. No evidence of silicosis or CWP.
04 27 1991	DX 45 (EX 2)	Vuskovich, B	Film quality 1; No pneumo. Extensive fibrotic changes in both apices with distortion of hilar structure. Status post active TB.
04 27 1991	DX 76, pp. 92,87	Broudy, B/BCR	Film quality 1; negative for pneumoconiosis, possible healed granulomatous disease, scattered calcifications most likely due to tuberculosis or histoplasmosis
04 27 1991	EX 14, p. 11	Repsher, B	Film quality 2 (dark); negative for pneumoconiosis; em; tb; Biapical granulomatous disease.
10 20 1999	DX 76, p. 100	Sargent, B/BCR	Film quality 1; pneumoconiosis s/t; 4 zones; 0/1, old tb, ? old granulomatous disease, ? lung volume loss, ? Hilarodenopathy, need additional studies, correlate clinically
10 20 1999	EX 9, p.10	Rosenberg, B	Film quality 2 (light film); negative for pneumoconiosis; ca: di; hi; 5 cm mass noted under R 1st Rib and clavicle; now apparent linear and nodular densities throughout lungs; film would be "recorded" as having parenchymal opacities if viewed out of context from clinical information.
10 20 1999	DX 76, p. 94	Barrett, B/BCR	Film quality 1; pneumoconiosis p/q; 1/2; 6 zones; category B large opacities, (di) marked distortion of the intrathoracic organs, emphysema

Date	Exhibit	Physician/ Qualifications[4]	Interpretation for Pneumoconiosis
10 20 1999	DX 76, p. 118	Younes, B	Film quality 1; r/q; 2/1; 6 zones; Category A large opacities; hi; questionable right upper lobe large opacity. CT scan of the chest is recommended, both hilar are retracted upward
10 20 1999	CX 8[5]	Broudy, B/BCR	Film quality 3 (haziness and underpenetration); r/q; 4 zones; 2/3; other abnormalities
11 17 1999	CX 3	Alexander, B/BCR	Film quality is 1. The lung volumes are normal. Small round and irregular opacities are present bilaterally, consistent with pneumoconiosis, category p/q, 2/1. Some "t" opacities are also present. Areas of coalescence are present in both upper zones. A large opacity measuring 20mm in diameter is present in the left upper zone, and a less well-defined large opacity measuring approximately 40mm in diameter is present in the right upper zone, indicating category B complicated pneumoconiosis. No chest wall pleural thickening or pleural calcifications are present. The costophrenic angles and diaphragms are clear, excluding slight scarring above the medial third of the left diaphragm. There is significant superior retraction of both hila due to the bilateral upper zone fibrotic masses of complicated Coal Worker's Pneumoconiosis. Otherwise, the cardiomediastinal structures and distribution of the pulmonary vasculature are normal. The bones are intact. Impression, Complicated coal worker's pneumoconiosis, category B, p/q, 2/1, ax, di.
11 17 1999	DX 76, p. 84	Broudy, B/BCR	Film quality 1; negative for pneumoconiosis
11 17 1999	EX 14, p. 12	Repsher, B	Film quality 1; negative for pneumoconiosis; em; tb.
11 17 1999	CX 2	Miller, B/BCR	Film quality 1; q/p; 1/2, 6 zones; Category A large opacities consistent with complicated pneumoconiosis A, Right pleural calcification, extent 2. Bilateral apical scarring with upward retraction on the hila (di) Coalescence of small pneumoconiotic opacities (ax). Epigastric surgical clips; Findings consistent with complicated pneumoconiosis A, category q/p, profusion 1/2; Right pleural calcification, extent 2; Grade C left lateral pleural thickening, extent 1.

Pulmonary Function Studies:

Date	Exhibit	FVC	FEV_1	MVV	Comment
12/1/86	DX 20	3.71	3.13	127	Pre-bronchodilator
		3.98	3.44	125	Post-bronchodilator
1/19/87	DX 16	3.5	3.2	3.5	

[5] This exhibit was attached to Claimant's Brief as additional medical evidence. This X-ray reading by Dr. Broudy was discussed during his deposition on February 16, 2000. Employer had the opportunity to examine Dr. Broudy during his deposition regarding this X-ray reading, and Employer has not objected to its admission. In the absence of any objection, Claimant's Exhibit 8 is admitted.

Date	Exhibit	FVC	FEV_1	MVV	Comment
2/18/87	DX 10	3.59	3.04	170	On spirometry the patient's effort was good. The study shows a slight restrictive ventilary defect but the MVV is 108% of predicted. The vital capacity is 73% of predicted and the FEV-1 is 77% of predicted. The results easily exceed the minimum Federal criteria for disability in coal workers.
5/7/87	DX 11, 22	3.78	3.2	109	Interpretation: FVC 3.78 liters 74.3% of the predicted value. FEV1 3.20 liters 82.9% of the predicted value. FEV1% 84.7, MVV 109 liters 70% of the predicted value. Understanding of the test good. Co-operation of the test fair. Impression: Mild restrictive ventilatory defect.
8/6/87	DX 12	3.85	3.38	135	Patient was cooperative with variable efforts
4/27/91	DX 45 (EX 2)	3.36	2.83	85	Poor Cooperation; Patient would not make the effort necessary to generate valid pulmonary function studies; numbers generated show mild impairment, well above the Federal guidelines for total disability.
5/5/91	DX 46 CX 1	2.78	2.60	37	Dr. Lane found this study invalid upon review, finding that each of the three studies differed in magnitude and contour. (DX 49, formerly EX 5).
10/20/99	DX 76, p. 115	3.64 3.84	2.65 2.77	101.05 N/S	Pre-bronchodilator Post-bronchodilator
11/17/99	DX 76, p. 80-81	3.58 3.53	2.49 2.59	104 109	Pre-bronchodilator Post-bronchodilator Fairly good effort, some coughing on MVV; mild to moderate impairment with elements of both obstruction and restriction. No response to bronchodilation. Results exceed the minimum federal criteria for disability.

Arterial Blood Gas Studies:

Date	Exhibit	$pC0_2$	$p0_2$	Comment
12/1/86	DX 20	42 35.9	96.9 104.4	Resting values Exercise values
1/19/87	DX 16	40	87	
2/18/87	DX 23	37.6	88.1	Diagnosis/Problem: ? Silicosis. Interpretation: The arterial blood gas study is normal.
5/7/87	DX 22, 24	38.8 40.2	93.8 93.7	Resting values Exercise values
8/6/87	DX 21, 25	37	85	

Date	Exhibit	$pC0_2$	$p0_2$	Comment
4/27/91	DX 45 (EX 2)	41	74	Impression: normal arterial blood gas studies.
10/20/99	DX 76, p. 107	38.8 40.0	83.6 84.7	Resting Exercised (Incremental exercise stress test exercised for 00:46 minutes stopped secondary to dyspnea/Bruce protocol)
11/17/99	DX 76, p. 82	41.1	95.4	Normal blood gas on room air

Physicians' Reports:

Claimant was admitted to Williamson Appalachian Regional Hospital on May 13, 1986, by Dr. Theodore Cherukuri. (DX 14). At that time Claimant's chest X-ray was read as negative. Dr. Cherukuri noted a history of pneumoconiosis, cardiopulmonary problems, tachycardia and myocardial ischemia, and peptic ulcer disease. No other respiratory or pulmonary conditions were noted, and Dr. Cherukuri did not make a finding regarding Claimant's respiratory capacity to return to coal mine employment. Also included in the medical records from Williamson Appalachian Regional Hospital are notations of a May 17, 1984, chest X-ray, which was negative, and several references to peptic ulcer disease dating to January, 1981. (DX 13, 14).

Dr. D.E. Shafer saw Claimant on October 10, 1986, for back problems. Dr. Shafer found that Claimant suffers a permanent partial disability of 17% due to chronic lumbar disc disease. She expressed no opinion regarding his pulmonary or respiratory ability. (DX 18).

Dr. Eugene Parr performed an orthopedic examination of Claimant on November 18, 1986. He opined that Claimant has a 5% permanent partial functional impairment to the body as a whole, based upon arthritis. Dr. Parr found that Claimant can return to coal mine employment from a physical standpoint, but expressed no opinion regarding his pulmonary or respiratory ability. (DX 19).

Dr. James K. Cooper, examined Claimant on December 1, 1986. Based on a coal mine employment history of 15 1/2 years, symptoms, medical history, family history, a smoking history of 25 pack years, physical examination, positive chest X-ray, normal arterial blood gas study, pulmonary function study, a normal EKG, and Claimant's statement that a 1985 skin test for tuberculosis was negative, Dr. Cooper diagnosed coal workers' pneumoconiosis. Dr. Cooper also found no evidence of significant restrictive disease, as the FVC was above the 95% confidence level. He stated that Claimant has the respiratory capacity to do his usual coal mine employment. (DX 20).

Dr. John M. Harrison examined Claimant on January 19, 1987. (DX 16). Based on a coal mine employment history of 15 1/2 years, symptoms, medical history, family history, a smoking history of 25 pack years, physical examination, positive chest X-ray, normal arterial blood gas study, and pulmonary function study, Dr. Harrison diagnosed mild restrictive lung disease and abnormal chest X-ray. He stated that the abnormal chest X-ray may not be coal workers' pneumoconiosis; it could be tuberculosis or sarcoidosis. However, Claimant told him

that his P.P.D. test was negative. He further stated that if pneumoconiosis should be found, Claimant should not return to coal mine employment. Otherwise, Dr. Harrison also found that Claimant should be able to perform coal mine employment from a respiratory standpoint. Dr. Harrison was deposed on March 17, 1987, in which he affirmed his diagnosis. At that time, he also stated that he believed that Claimant's X-ray results were more consistent with granulomatous disease because that is a hilar adenopathy, and because Claimant was only 40 years old at the time and had worked in the mines for 15 years. (DX 16).

Dr. Bruce Broudy examined Claimant on February 18, 1987, at the request of the Employer. (DX 15, 20A). Based on a coal mine employment history of 15 1/2 years, symptoms, medical history, family history, a smoking history of 1 pack per day for 20-22 years, physical examination, negative chest X-ray, normal arterial blood gas study, pulmonary function study, and a normal EKG, Dr. Broudy diagnosed no coal workers' pneumoconiosis and post inflammatory fibrotic change in both upper lung lobes, probably secondary to previous infectious disease. To this extent, Dr. Broudy noted that Claimant had no history of tuberculosis, yet he attributed the opacities to "healed inflammatory disease, most likely due to granulomatous disease from tuberculosis or histoplasmosis." He stated that Claimant retains the respiratory capacity to do his usual coal mine employment or similar work and has no significant pulmonary disease or respiratory impairment resulting from coal mine employment. Dr. Broudy affirmed his diagnosis in a deposition taken March 3, 1987. (DX 15).

Dr. R.V. Mettu examined Claimant on May 7, 1987. Based on a coal mine employment history of 15 years, symptoms, medical history, family history, a smoking history of 1/2 pack per day for 20 years, physical examination, positive chest X-ray, normal arterial blood gas study, and pulmonary function study, negative tuberculosis test in 1987, Dr. Mettu diagnosed: (1) chronic bronchitis; (2) arteriosclerotic heart disease with angina pectoris; (3) history of back injury, lumbo sacral strain; and, (4) abnormal X-ray related to coal mine employment. His medical assessment of limitations in physical activities that may be due to pulmonary disease indicated that Claimant can walk "1 block in 1985," can climb stairs "1 flight of stairs 1985," and that "He cannot lift or carry any weight because of back injury." Dr. Mettu also found that the pulmonary function study showed a mild restrictive ventilatory defect, but was a normal pulmonary physical. He stated that Claimant has an occupational lung disease due to coal mine employment with a mild impairment, but that Claimant has the respiratory capacity to do the work of a miner or comparable work in a dust free environment. (DX 22; DX 42, p. 61).

Dr. Robert Abernathy examined Claimant on August 6, 1987. Based on a coal mine employment history of 17 years, symptoms, medical history, family history, a smoking history of 1/2 pack per day, physical examination, positive chest X-ray, normal arterial blood gas study, and pulmonary function study, Dr. Abernathy diagnosed probable coal workers' pneumoconiosis, possible pulmonary tuberculosis, chronic bronchitis, and mitral valve prolapse. Regarding the possible tuberculosis, he indicated this should be investigated further with sputum examinations. Dr. Abernathy found no impairment related to coal dust exposure and stated Claimant should be able to do his usual coal mine employment. (DX 21).

Dr. Sutin Srisumrid testified by deposition taken September 2, 1987, regarding chest X-rays (dated 7/10/84 and 5/14/86) of Claimant which he read. Dr. Srisumrid testified that he is a

Board Certified Radiologist and an "A" reader under the NIOSH program. He states that while he found no evidence of pneumoconiosis, he did note a fibrotic scar from both hilar to the upper lobes bilaterally, but that such is not related to pneumoconiosis. He opined that what he saw was a scar, which is not consistent with the nodules of pneumoconiosis, and was consistent with an infection. (DX 36).

Dr. Emery Lane reviewed medical evidence submitted to him by Employer on June 21, 1988. Dr. Lane noted Claimant's 15 1/2 year-history of coal mine employment and his one pack per day cigarette smoking for 20-22 years. He diagnosed coal workers' pneumoconiosis, and possible tuberculosis or sarcoidosis. He noted that the pulmonary function studies show a mild restrictive defect and the arterial blood gas studies are normal. Dr. Lane stated that Claimant does retain the respiratory capacity to return to work and perform the work of an underground coal miner. He further stated that it is unclear from the evidence whether there is any impairment from coal mine employment. (DX 42, pp. 21-23).

Dr. Gregory J. Fino reviewed medical records provided to him by counsel for Employer on August 10, 1990. He stated that it was difficult to determine whether Claimant has pneumoconiosis without reviewing the actual X-ray films, but that for the purpose of his opinion, he would assume Claimant has simple pneumoconiosis by relying on the lung function studies and the arterial blood gas studies. He that Claimant's ventilatory function is normal and that there is no impairment in the transfer of oxygen. Dr. Fino opined that Claimant's coughing and mucus production were due to Claimant's 1/2 pack per day of cigarette smoking over the preceding 26 years. Dr. Fino stated that Claimant has no respiratory impairment and retains the respiratory ability to return to work and perform the job of an underground coal miner. (DX 44, formerly EX 1).

Dr. Matt Vuskovich examined Claimant on April 27, 1991. Based on a coal mine employment history of 15 years, symptoms, medical history, family history, a smoking history of 30 pack years, physical examination, negative chest X-ray, normal arterial blood gas study, and pulmonary function study that showed inadequate effort, Dr. Vuskovich diagnosed hyperlipidemia with abnormal lipid profile, coronary heart disease by history, peptic ulcer disease by history, and status post active tuberculosis (even though his notes state that Claimant denied a history of tuberculosis). He stated that none of Claimant's conditions are related to coal mine employment and found no objective evidence of coal workers' pneumoconiosis. Dr. Vuskovich stated that Claimant is able to return to coal mine employment or similar work from a pulmonary standpoint. (DX 45, formerly EX 2).

Dr. Terry L. Wright examined Claimant on May 5, 1991. Based on a coal mine employment history of 15 years, symptoms, medical history, family history, a smoking history of 30 pack years, physical examination, negative chest X-ray, normal arterial blood gas study, and pulmonary function study, Dr. Wright diagnosed coal workers' pneumoconiosis category 1 with moderate restrictive defect. (DX 46, formerly CX 1).

Dr. Rosario L. Nadorra examined Claimant on February 21, 1992, for an evaluation of lupus. Dr. Nadorra noted Claimant's history of "black lung." When he examined Claimant, he noted that his lung sounds were clear. (CX 6, pp. 1-2).

Dr. Nadorra examined Claimant again on March 19, 1992. Dr. Nadorra again noted clear lung sounds and diagnosed him with lupus. (CX 6, p. 3).

Claimant was seen by Dr. Nadorra on May 4, 1992, at which time Claimant noted that he had been experiencing chest pains on his left side for five days. Dr. Nadorra noted that a chest X-ray showed an irregular shaped suprahilar density on the left side and also noted decreased breath sounds. Dr. Nadorra sought to rule out Lupus Pneumonitis and Bacterial Pneumonitis. The notes appear to indicate that Claimant was admitted to the hospital. (CX 6, pp. 3-4).

Claimant was seen by Dr. Nadorra on May 20, 1992. Dr. Nadorra notes that Claimant had multilobar pneumonia and had improved since being started on Erythromycin. Claimant's lungs were clear upon examination. Claimant was diagnosed with multilobar pneumonia and discoid lupus. (CX 6, p. 4).

Claimant saw Dr. Nadorra on May 27, 1992. Claimant's condition had improved, and Dr. Nadorra noted, "Lungs: clear, sl. diminished, L." The notes also state: "CXR (discussed with Dr. Kim): L basal infiltrate much improved; L suprahilar prominence." Dr. Nadorra used the SOAP method of evaluation and noted under "A": Legionella pneumonia and L suprahilar prominence; and under "P": CT chest. (CX 6, p. 5).

Claimant saw Dr. Nadorra on June 25, 1992, at which time Claimant's lungs were noted as clear, and it was noted under "A" of the SOAP method that Claimant had discoid lupus and coal workers' pneumoconiosis. (CX 6, p. 6).

Dr. Nadorra examined Claimant on August 25, 1992. Dr. Nadorra noted that Claimant had quit smoking altogether and that he had knee pain. His lungs were clear, and coal workers' pneumoconiosis and discoid lupus were again noted. (CX 6, pp. 6-7).

Claimant was doing well when he saw Dr. Nadorra on October 26, 1992. Claimant's joint pain had been relieved but he continued to have elbow and back pain. Claimant's lungs were clear, and coal workers' pneumoconiosis and discoid lupus were again noted, as was right lateral epicondylitis. (CX 6, p. 7).

Claimant returned to Dr. Nadorra's office on December 4, 1992, for an unscheduled visit, due to increased joint pain and anxiety attacks. Claimant's lungs were clear. He was diagnosed with anxiety disorder. (CX 6, p. 8).

On December 22, 1992, Claimant was again examined by Dr. Nadorra, who noted he was doing better and not having anxiety attacks. Claimant's lungs remained clear. Dr. Nadorra maintained his diagnosis of anxiety disorder. (CX 6, p. 9).

Claimant's lungs remained clear when he visited Dr. Nadorra on February 22, 1993, (CX 6, p. 9), and June 4, 1993, (CX 6, p. 10), when Dr. Nadorra again noted that Claimant had pneumoconiosis.

Claimant was admitted to Williamson Memorial Hospital on June 27, 1993, and was discharged on July 1, 1993, with a final diagnosis of: Mycoplasma pneumonia; Systemic lupus erythematosus; and Coal worker's pneumoconiosis. Dr. Nadorra was the attending physician. (CX 6, p. 51).

On July 9, 1993, Dr. Nadorra examined Claimant and noted that he had pneumonia from June 27 to July 1, 1993. His lungs were clear at that time. Dr. Nadorra diagnosed mycoplasma pneumonia and noted "suspect GERD." (CX 6, p. 11).

On July 23, 1993, Dr. Nadorra saw Claimant. He noted that Claimant's chest X-ray showed "acute RUL infiltrate resolved." His lungs were clear, and Dr. Nadorra again noted pneumoconiosis. (CX 6, p. 12).

Claimant visited Dr. Nadorra's office on September 10, 1993, for an unscheduled visit, as he was coughing up yellowish phlegm and had pain when coughing. Dr. Nadorra noted upon examination that Claimant had diffuse rhonchi sounds in his lungs and diagnosed acute bronchitis. (CX 6, p. 12).

Claimant called Dr. Nadorra's office on October 11, 1993, complaining of a bad cough and coughing up thick mucus. He was told to get a chest X-ray, but when the doctor's office followed up with Claimant two days later, they were told that Claimant had refused to go to the doctor. (CX 6, p. 13).

Claimant was seen by Dr. Nadorra on October 22, 1993, still complaining of a cough and coughing up white to yellowish phlegm. Dr. Nadorra noted that his lungs were clear, and diagnosed him again with acute bronchitis. (CX 6, p. 14).

Claimant went back to Dr. Nadorra's office on November 3, 1993, and was still coughing. His lungs were clear, and Dr. Nadorra diagnosed him with acute sinusitis. (CX 6, p. 15).

When Claimant saw Dr. Nadorra on February 1, 1994, the doctor noted that Claimant was still smoking, and his lungs were clear. Dr. Nadorra diagnosed pneumoconiosis. (CX 6, p. 16).

Claimant's lungs were clear when he saw Dr. Nadorra on May 16, 1994. He was diagnosed with depression. (CX 6, p. 17).

Claimant came to Dr. Nadorra's office for an unscheduled visit on September 6, 1994, complaining of a chest cold. Dr. Nadorra noted diffuse rhonchi in his lungs and diagnosed acute bronchitis. (CX 6, p. 18).

When Claimant saw Dr. Nadorra on November 14, 1994, the doctor noted clear lungs and a diagnosis of COPD. (CX 6, p. 19). Claimant's lungs were still clear when Dr. Nadorra saw him on February 16, 1995, (CX 6, p. 20); and March 3, 1995 (CX 6, p. 20).

Dr. Nadorra examined Claimant on April 10, 1995, noting bronchial breath sounds with a few rhonchi. The doctor also noted: "CXR: 0 new infilt." Dr. Nadorra diagnosed acute bronchitis, pneumoconiosis, and anxiety disorder. (CX 6, p. 21).

On May 4, 1995, Claimant saw Dr. Nadorra, complaining of congestion and coughing. His lungs were clear at that time. He was again diagnosed with acute bronchitis. (CX 6, p. 22).

Claimant's condition had improved when Dr. Nadorra saw him on June 16, 1995. A chest X-ray taken at the emergency room three weeks prior was negative for pneumonia. His lungs were clear, and Dr. Nadorra maintained his diagnosis of COPD. (CX 6, pp. 22-23).

Claimant's lungs remained clear and Dr. Nadorra maintained his diagnosis of COPD when he examined Claimant on September 14, 1995. (CX 6, p. 23).

Claimant was seen by Dr. Nadorra on October 25, 1995, after visiting the emergency room and being diagnosed there with acute bronchitis. Claimant's lungs were clear, and Dr. Nadorra diagnosed COPD and acute bronchitis. (CX 6, p. 24).

Claimant was seen by Dr. Nadorra for a follow-up examination on March 22, 1996. His lungs were clear, and Dr. Nadorra diagnosed COPD and pneumoconiosis. (CX 6, p. 25).

Claimant was admitted to Williamson Memorial Hospital on April 15, 1996, and was discharged on April 18, 1996. The discharge diagnoses were: Pneumonia, right upper lung; Coal worker's pneumoconiosis; Systemic lupus erythematosus; Chronic obstructive pulmonary disease with acute exacerbation; and Anxiety depression. Dr. Nadorra is noted as the physician. (CX 6, p. 48). Claimant's past medical history notes significant for lupus, anxiety disorder, and coal worker's pneumoconiosis. (CX 6, p. 49).

Claimant had another follow up visit with Dr. Nadorra on April 25, 1996, at which time Dr. Nadorra noted that Claimant was doing well, and that a breathing machine had been helping Claimant. Claimant's lungs were clear, and he was diagnosed with pneumonia at that time. (CX 6, p. 26).

Dr. Nadorra examined Claimant again on July 23, 1996, and Claimant was complaining of coughing up yellow phlegm. His lungs were clear, and Dr. Nadorra diagnosed COPD with acute exacerbation. (CX 6, p. 27).

Claimant had a follow up appointment with Dr. Nadorra on October 23, 1996. The doctor noted that Claimant was doing well, but had pain in his right shoulder and neck. His lungs were clear. Dr. Nadorra diagnosed acute cervical strain, and Claimant was given medication for pain and a cervical collar. (CX 6, p. 28).

Claimant saw Dr. Nadorra on November 7, 1996, with continuing pain in his right shoulder going down to his hand. His neck pain had improved. Dr. Nadorra diagnosed chronic cervical strain and administered an injection of what appears to read lidocaine. (CX 6, p. 29).

Claimant returned to Dr. Nadorra's office on November 26, 1996, at which time his right shoulder was better. His lungs were clear. (CX 6, p. 30). However, when he returned on February 26, 1997, Claimant was again having right shoulder problems. Dr. Nadorra diagnosed subdeltoid bursitis and chronic cervical strain and again injected Claimant with lidocaine. (CX 6, p. 31).

When Claimant saw Dr. Nadorra on March 12, 1997, his shoulder doing better but he had pain from his neck to his head. His lungs were clear, and he was diagnosed with shoulder arthritis and chronic cervical strain, and prescribed Darvocet. (CX 6, pp. 31-32).

Claimant returned to Dr. Nadorra's office on July 11, 1997, and was doing well, except for some pain in his neck and shoulders. His lungs were clear. (CX 6, pp. 32-33).

On September 2, 1997, Claimant was doing well, but feeling weak and "run down." His lungs were clear. (CX 6, pp. 33-34).

A discharge summary from Williamson Memorial Hospital notes an admission date of September 23, 1997, and a discharge date of September 25, 1997. The discharge diagnoses are: Acute pneumonitis with pleurisy; systemic lupus erythematosus; coal worker's pneumoconiosis; and anxiety disorder. Dr. Nadorra is noted as the physician. (CX 6, p. 46).

Claimant saw Dr. Nadorra on October 9, 1997, at which time he stated that he wanted to quit smoking. His lungs were clear. Dr. Nadorra noted his diagnosis of coal workers' pneumoconiosis. (CX 6, pp. 34-35).

A follow-up appointment with Dr. Nadorra occurred on January 9, 1998. Claimant was doing well and had cut back on smoking. Dr. Nadorra again noted his diagnosis of coal workers' pneumoconiosis. (CX 6, p. 35). When he saw Claimant on May 6, 1998, Dr. Nadorra again noted that Claimant was doing well except for some knee problems and that he had cut back on his smoking. (CX 6, p. 36).

Dr. Nadorra saw Claimant again on September 30, 1998. Claimant was doing well, but had severe bronchitis two weeks prior. Upon examination, Dr. Nadorra noted that Claimant had fair air entry in his lungs with no rhonchi or crackles. Dr. Nadorra maintained his diagnosis of coal workers' pneumoconiosis. (CX 6, p. 37).

Claimant came to Dr. Nadorra's office for an unscheduled visit on February 18, 1999, because he was coughing up yellow phlegm; however, he was feeling better. Dr. Nadorra noted that Claimant was still smoking. Dr. Nadorra noted diffuse rhonchi in his lungs, and diagnosed COPD with acute exacerbation and noted the necessity to rule out pneumonia. (CX 6, p. 38).

On a follow up visit on March 31, 1999, Claimant felt better, and his lungs were clear. Dr. Nadorra diagnosed COPD. (CX 6, pp. 38-39).

Claimant had another follow up appointment on September 30, 1999. His lupus was doing fine; however, since his previous visit, a polyp was found, and Claimant underwent a

colonoscopy. Claimant's lungs were clear, and Dr. Nadorra maintained his diagnosis of COPD. (CX 6, p. 39).

Dr. Maan Younes performed an examination of Claimant for coal workers' pneumoconiosis on October 20, 1999. His examination consisted of medical, employment, and social histories, physical examination, blood gas and pulmonary function studies, and a chest X-ray. As a result of his examination, he diagnosed coal workers' pneumoconiosis, chronic obstructive pulmonary disease. He opined that Claimant has a moderate obstructive ventilatory impairment due to pneumoconiosis and COPD, and that such "may interfere with last coal mining job." He concluded that Claimant does have an occupational lung disease caused by his coal mine employment, as evidenced by the chest X-ray, and that he has a moderate impairment, caused primarily by occupational dust exposure, and that he does not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust free environment. (DX 76, pp. 102-18).

On November 15, 1999, a tuberculin skin test was administered to Claimant. According to the certificate issued by the Pike County Health Department, in Belfry, Kentucky, Dr. Broudy read this skin test on November 17, 1999. In the section labeled "Millimeters of Induration," "0 mm" is noted. (CX 4).

Dr. Bruce Broudy performed an occupational pulmonary examination of Claimant on November 17, 1999. The examination consisted of a chest X-ray, CT scan of the chest, spirometry, arterial blood gases, history and physical examination. He also reviewed other medical evidence. Dr. Broudy reports that Claimant has no history of tuberculosis or carcinoma. Claimant does have trouble breathing and has shortness of breath. Claimant also reported to Dr. Broudy that he could walk satisfactorily on level ground, but could not go uphill or carry groceries. Based on his examination, he diagnosed "Abnormal chest x-ray with evidence of healed granulomatous disease; depression and anxiety; mild to moderate respiratory impairment largely due to restriction and mild obstruction." He opines that he does not believe that Claimant has coal workers' pneumoconiosis and that he has the respiratory capacity to perform the work of an underground coal miner or similarly arduous work. (DX 76, pp. 72-78).

Dr. Ray Polisetty[6] reviewed a chest X-ray dated November 17, 1999, on November 22, 1999, upon referral from Dr. Broudy. Dr. Polisetty compared this X-ray with the one taken on February 18, 1987, and noted fibronodular changes in both lungs, predominantly in the upper lobes with elevation of both hila. Dr. Polisetty also found some pleural scarring on the right and slight tenting of the left diaphragm. In Dr. Polisetty's opinion, these changes were consistent with pneumoconiosis. Dr. Polisetty also wrote in his report that the changes were "somewhat progressive with more scarring from previous study of 1987." Further, he noted "vague densities" in the right and left upper fields "including a suggestion of a mass density in the right upper lung field" which "probably represents some conglomeration of the pneumoconiotic

[6] According to the National Institute for Occupational Safety and Health, Division of Respiratory Disease Studies List of Certified Roentgenographic Interpreting Physicians "B" Readers Comprehensive List, Dr. Polisetty was a B reader from 1986 to 1990. The Current List of B readers does not list Dr. Polisetty as a current B reader.

nodules with progression from previous study." Dr. Polisetty suggested further evaluation of the right upper lung mass density. (CX 9).[7]

Dr. Maan Younes examined Claimant on December 9, 1999, for evaluation of an abnormal chest X-ray. He took a history of Claimant's symptoms, a chest X-ray and performed his physical examination. Dr. Younes noted that the X-ray taken on that date was unchanged from the one taken in February, 1999, that he reviewed. Dr. Younes opined that Claimant has complicated pneumoconiosis, mild COPD, arthritis, dyslipidemia, and depression. (DX 76, pp. 64-65).

By letter dated January 11, 2000, Dr. Younes stated that he reviewed Claimant's medical records, including the evaluation by Dr. Broudy. Dr. Younes stated that his opinion as to Claimant's condition remains unchanged and that he still believes Claimant has complicated pneumoconiosis. In his review of Claimant's X-rays, Dr. Younes found small rounded opacities size p/q with a profusion of 2/1, and large opacities of size Category A. Based upon Claimant's coal mine employment history, the fact that he has no previous history of tuberculosis or sarcoidosis, and the X-ray readings, Dr. Younes found that the only available etiology for the finding of complicated pneumoconiosis is Claimant's occupational dust exposure. (DX 76, p. 67).

When Claimant was seen on February 3, 2000, by Dr. Nadorra he stated that he had pain in his knees at times. He had a COPD exacerbation around New Year's day, but recovered. He had quit smoking. Claimant's lungs were clear, and Dr. Nadorra again noted COPD and also complicated pneumoconiosis. (CX 6, p. 40).

Dr. Broudy testified by deposition taken on February 16, 2000, regarding his examination of Claimant. He testified that he had examined Claimant twice, on February 18, 1987, and again on November 17, 1999. Dr. Broudy testified that Claimant's smoking history was sufficient to cause pulmonary disease, and, in particular, chronic obstructive pulmonary disease. He testified that the X-ray evidence he had reviewed did not show any evidence of coal workers' pneumoconiosis, simple or complicated. He states he did see increased opacities in the upper lobes with some retraction of the hilar structures superiorly, as one can see with chronic fibrotic change. However, these did not look like the large opacities of coal workers' pneumoconiosis, "although I suspect some of the positive interpretations resulted from misinterpretation of these findings." Therefore, he opined that Claimant does not have coal workers' pneumoconiosis, but stated that the changes were highly suggestive of healed granulomatous disease such as tuberculosis or histoplasmosis. Dr. Broudy stated that it is possible for a person to have tuberculosis and never know it. Dr. Broudy further stated, however, that if a person had tuberculosis, the germ would remain in the body if no treatment was administered; the same would apply to histoplasmosis. He also opined that Claimant does not have any impairment related to the inhalation of coal dust. Even assuming that Claimant does have simple pneumoconiosis, he opined that he does not have any impairment caused by such and has the

[7] This exhibit was attached to Claimant's Brief as additional medical evidence. Employer had the opportunity to submit its own medical evidence regarding the two X-rays that Dr. Polisetty discusses, and Employer has not objected to the admission of this exhibit. In the absence of any objection, Claimant's Exhibit 9 is admitted.

respiratory capacity to return to his previous job as an underground coal miner. (DX 76, pp. 1-30).

Dr. David M. Rosenberg reviewed medical reports of Claimant on August 29, 2000. Dr. Rosenberg opined that Claimant's pulmonary function studies revealed that he had, at most, a mild restriction with mild-moderate degree of airflow obstruction. He believed that this probably related to the retraction of the upper lung fields combined with poor effort, and that it was not related to his coal mine employment but instead to his past history of smoking. Based on his review of the medical evidence, he states that Claimant had clear lung fields on chest X-rays in the early 1980's, without the presence of any background pneumoconiosis. A CAT Scan did not demonstrate any background evidence of pneumoconiosis. Beginning in the mid 1980's, he states that some streaking from the hilar regions to the apices has been noted, associated with volume loss and possible hilar adenopathy, and that subsequently, there has been progression of this fibrotic scarring with large opacity formation. However, Dr. Rosenberg differentiates between the "recording" of abnormalities found, versus the "interpretation" of such findings. He states that while many B readers have "recorded" changes consistent with the presence of a pneumoconiosis, when one "interprets" the fact that the upper lobe abnormalities (linear streaking and volume loss with retraction) have occurred without a background of small nodular opacities (not on early films from the early 1980's or a more recent CT scan of the chest), the presence of coal workers' pneumoconiosis (CWP) is improbable. He opines that for these changes to be related to past coal dust exposure, a preceding history of simple CWP would have been present. Therefore, he opines that "Mr. Maynard's chest X-ray abnormalities should not be 'recorded' as being caused by a CWP. The findings probably relate to old granulomatous disease or conceivably sarcoidosis." Therefore, Dr. Rosenberg believed that Claimant retained the respiratory capabilities of performing underground coal mine employment. (EX 9).[8]

Dr. Gregory Fino reviewed medical records of Claimant on September 11, 2000. Based upon his review, he states that his earlier opinion has not changed and opines that simple coal workers' pneumoconiosis is present. Dr. Fino noted that, based upon his review of Claimant's medical records, he found no evidence of respiratory impairment or pulmonary disability. It was Dr. Fino's opinion that Claimant never gave a maximum effort on the spirometric evaluations. (EX 10).

Dr. E.N. Sargent, on September 12, 2000, read a chest X-ray dated October 26, 1985, and compared it with other films of Claimant's chest. He opines that there is evidence of progressive loss of lung volume in the upper lobes with some retraction of the hilar shadows superiorly. He states that "This is a confounding factor in the classification system. It causes accentuation of the opacities that will be recorded." He opines that the findings appear to be associated with old granulomatous disease in the upper lobes, and that smoking, even second-hand smoking, is also a confounding factor. Further, he states that after reviewing all of the films and allowing for differences in technique, as well as a loss of lung volume in the upper lobes, the classification under the ILO system is s/t 0/1 in the upper and middle lung zones. The differential diagnosis

[8] Employer exhibits 1-8 have been renumbered by the District Director when this case was last forwarded to the Office of Administrative Law Judges. Employer exhibits submitted since then are numbered beginning with EX 9 to avoid confusion with the earlier EX 1 through EX 8 exhibits.

between coal worker's pneumoconiosis and granulomatous disease such as sarcoidosis or other unusual fungal disease could be made by means of a lung biopsy. Computer tomography might also be of value. (EX 11).

Dr. Nadorra saw Claimant on September 13, 2000, and noted no lupus flare up. His lungs were clear. Dr. Nadorra noted complicated pneumoconiosis. Claimant was advised during this visit that Dr. Nadorra would no longer be admitting patients for medical diagnosis. (CX 6, p. 41).

Dr. Sargent testified by deposition taken October 6, 2000, regarding his review of the X-rays submitted to him and regarding his qualifications and involvement in the creation of the B reader program. Dr. Sargent stated that he is also a consultant in the Black Lung Program for the Department of Labor and reads X-ray films that are sent to him from the department. No medical history or additional medical records accompany the X-rays when he receives them. (EX 13, pp. 12, 14-15). As to his review of X-rays taken in May, 1987, and October, 1999, at the request of the Department of Labor, Dr. Sargent testified that he could not explain why he noted a profusion of 1/1 in 1987, but in 1999, noted a profusion of 0/1. He stated that he did not have the May, 1987, X-ray to compare when he was reading the October, 1999, X-ray, as he was told upon his request to the Department of Labor that the 1987 X-ray was not available. Based on the review of the October, 1999, X-ray, Dr. Sargent opined that Claimant did not have coal workers' pneumoconiosis. (EX 13, p. 41). After reviewing the two films for the Department of Labor, counsel for Employer forwarded Claimant's X-rays and medical evidence to Dr. Sargent for his review, and he summarized those findings in a letter dated September 12, 2000. (EX 13, pp. 42-43).

Claimant was seen by Dr. Nadorra on March 13, 2001, at which time he related to the doctor that he was doing well, but that he had a cold all winter. His lungs were clear. (CX 6, p. 42).

Claimant returned to Dr. Nadorra's office on September 13, 2001, for bilateral pain in his knees. His lungs were clear upon examination. (CX 6, p. 42).

On September 14, 2001, a Histoplasma test was administered by Laboratory Corporation of America. The results of the specimen were reported on September 18, 2001. The result of the report was negative. (CX 5).

Dr. Repsher reviewed Claimant's medical records and issued his report summarizing his findings on October 17, 2001. (EX 14). Dr. Repsher noted a 30 pack year smoking history for Claimant and his 15-year coal mining employment history. He also noted his medical history as well as his family medical history. Dr. Repsher also reviewed several X-rays, noting his findings on ILO forms. In Dr. Repsher's opinion, the X-rays show "slowly progressive biapical granulomatous disease, but no evidence of coal workers pneumoconiosis. There is also evidence of emphysema." (EX 14, p.3). Dr. Repsher's review of a CT scan dated November 17, 1999, showed no evidence of coal workers pneumoconiosis but did show biapical pleural based masses with some minimal calcification and several smaller pleural based scars of unclear etiology, which he believed were most likely due to an indolent infection. (EX 14, p. 3). Dr. Repsher

noted the "great deal of variation" in the interpretation of Claimant's X-rays, and wrote that "the CT scan obtained by Dr. Broudy clearly documents that there are no lesions of simple pneumoconiosis, which would essentially rule out complicated coal workers pneumoconiosis or PMF. Further, the CT scan shows that these masses are all pleural based." As to Claimant's pulmonary function tests, Dr. Repsher opined that the tested were within the normal limits, as were serial electrocardiograms. (EX 14, p. 4).

Dr. Repsher's impressions were: No evidence of coal workers pneumoconiosis, either simple coal workers pneumoconiosis or progressive massive fibrosis; Probable normal pulmonary function, despite long history of cigarette smoking; Disabled by chronic low back pain, secondary to work injuries x 2; Paroxysmal atrial fibrillation, controlled with Digoxin and Inderal; Probable underlying coronary artery disease, manifested by angina pectoris by history; GERD; chronic depressive reaction; and lupus arthritis. (EX 14, p. 5). Dr. Repsher stated that Claimant had the respiratory ability to continue to work as an underground coal miner. (EX 14, p. 6).

Dr. Rosenberg's deposition was taken by Employer on November 19, 2001. (EX 16). Dr. Rosenberg reviewed Claimant's medical records, including medical reports, depositions, and X-rays, and summarized his findings in a report dated August 29, 2000. (EX 16, p. 4). Dr. Rosenberg found no radiographic evidence of coal workers' pneumoconiosis on the X-rays, noting that Claimant exhibited no "background micronodular changes." He did find abnormalities in terms of a loss of volume in the upper lung fields. He also observed a large nodular mass approximately 5 centimeters under the first right rib and clavicle. (EX 16, pp. 5-6). As to Claimant's other tests, Dr. Rosenberg opined that his arterial blood gas studies were normal and that Claimant had, at worst, a mild degree of airflow obstruction. (EX 16, p. 7).

Dr. Rosenberg testified that tuberculosis as well as sarcoidosis can mimic coal workers' pneumoconiosis on an X-ray. To this extent, a negative tuberculosis skin test was not dispositive of whether a patient had tuberculosis because newly diagnosed tuberculosis patients can have negative skin tests. (EX 16, p. 9). A biopsy would definitively determine whether Claimant has tuberculosis. (EX 16, p. 10). In Dr. Rosenberg's opinion, Claimant does not have either simple or complicated pneumoconiosis; therefore, he believes that any impairment or disability that Claimant has is caused by a granulomatous or inflammatory process in his upper lung fields. (EX 16, pp. 11-12). When questioned on cross-examination, however, Dr. Rosenberg testified that he did not check the box for tuberculosis on the ILO form when reviewing Claimant's X-rays because he did not think that Claimant had active tuberculosis. (EX 16, p. 14). Based upon the studies he reviewed, Dr. Rosenberg opined that Claimant retains the respiratory capacity to return to the mining industry and perform his previous job. (EX 16, p. 12).

Dr. Repsher's deposition was taken by Employer on November 26, 2001. (EX 17). Dr. Repsher's stated that he reviewed Claimant's medical records upon request from Employer's counsel in October, 2001. (EX 17, p. 3). From the records, Dr. Repsher was able to discern Claimant's 15-year work history as a coal miner and his 30 pack-year history as a smoker. (EX 17, p. 4). Dr. Respher was also able to discern Claimant's medical history, including a history of testing negative on TB skin tests. (EX 17, p. 5). Dr. Repsher reviewed all of the X-ray interpretations provided to him, as well as various chest X-rays dating from 1985 to 1999 and a

CT scan. Dr. Repsher opined that Claimant exhibited no evidence of pneumoconiosis but did exhibit evidence of biapical granulomatous disease which appeared to progress over time. Dr. Repsher also found evidence of either emphysema or COPD. (EX 17, p. 6, 11). When examining Claimant's X-rays, Dr. Repsher noted "simple TB." He testified, however, that this notation was not an actual diagnosis of tuberculosis, but rather, he noted tuberculosis because "[t]here's nothing there that you can check for biapical granulomatous disease." (EX 17, p. 19).

Dr. Repsher noted only minor progression in the earlier X-rays, and that the X-rays showed a stable condition since 1996. Dr. Repsher noted that if Claimant had healed tuberculosis or other granulomatous disease, that would remain stable when viewed on the X-rays. (EX 17, p. 14). According to Dr. Repsher, granulomatous scars that are limited to the apex of the lungs "virtually never cause any lung function impairment in general" and based upon this fact and that Claimant's lung function tests were "good," Dr. Repsher opined that Claimant was not having any difficulty at present, aside from some "modest airway obstruction," which was likely caused by his smoking habit. (EX 17, p. 13).

Dr. Repsher opined that the "conglomerate lesions" that he observed in the apices of Claimant's lungs were "quite typical of tuberculosis." (EX 17, p. 11). Even taking into account that Claimant had negative tuberculosis skin tests in 1995 and 1999, Dr. Repsher stated that, "In a 55 year old man it would suggest that he doesn't have typical human tuberculosis infection, but it doesn't tell us whether or not he has coal workers pneumoconiosis because there are other explanations for the biapical granulomatous disease, namely sarcoidosis, histoplasmosis, and most importantly atypical tuberculosis which would not be associated with a positive skin test." However, Dr. Repsher stated that the tests for atypical tuberculosis are not generally available. (EX 17, p. 12). To this extent, Dr. Repsher testified that if one of his patients had a negative tuberculosis skin test and X-ray changes such as Claimant has, there would be nothing of any relevance that could be done, short of a biopsy, to determine whether that patient actually had tuberculosis, except taking a history to determine whether he was clinically ill. (EX 17, p. 21).

Dr. Repsher stated that negative tuberculosis tests are "irrelevant" to the issue of what the abnormalities are on Claimant's X-rays; instead, he stated that "Negative TB skin test is of no help in deciding what those lesions are. You have to decide what those lesions are based on other factors." Even a biopsy would not be helpful in Dr. Repsher's eyes. (EX 17, pp. 15-16). Dr. Repsher related that the only way to know what the lesion was would be to remove part of the upper lobe of the lung, but that this was not necessary since the lesions were not causing him any problems. (EX 17, p. 16). Based upon these findings, Dr. Repsher opined that Claimant did not have any impairment or disability that was related to inhalation of coal mine dust. (EX 17, p. 17). Therefore, Dr. Repsher found that Claimant would be able to perform "heavy work eight hours a day five or six days a week." (EX 17, p. 18).

A second deposition of Dr. Broudy was taken by Employer on December 3, 2001. (EX 18). During his evaluation of Claimant, Dr. Broudy read Claimant's tuberculosis test, which was negative. Dr. Broudy testified that this does not rule out the possibility of a previous tuberculosis infection or previous healed tuberculosis because "a positive test requires an intact immune system; so that if an individual has some type of immune deficit, they may not develop a positive reaction. But, more importantly is the fact, even if it was positive to begin with, it may wane

with time such that if an individual is retested many years later, the test may be negative, although it was positive at the time they were infected." According to Dr. Broudy, the age or the time between infection and testing would affect a tuberculosis test. (EX 18, pp. 3-4). Dr. Broudy found, based on his examination of Claimant, that he did not have simple or complicated coal workers' pneumoconiosis. (EX 18, p. 5). Dr. Broudy also gave similar testimony as to histoplasmosis, stating that if an individual carried the histoplasma germ, it would usually show up on a histoplasmosis tests. To this extent, Dr. Broudy testified that histoplasmosis tests were more consistently positive in patients with active disease, "but most—almost all the patients tested would have inactive disease.... Because almost everyone in Kentucky has been exposed to histo and has had a more or less self-limiting illness." (EX 18, p. 10).

Dr. Broudy also discussed his reading of an X-ray film dated October 20, 1999. Dr. Broudy testified that this film was of film quality 3 because of haziness and under-penetration. He read the film as 2/3, t/q, in the mid and upper zones. He also observed a Category 1 lesion in the upper right zone. He concluded that this film was consistent with complicated pneumoconiosis. Dr. Broudy also noted distortion of the hilar structures and retraction of the hilar structures superiorly. (EX 18, pp. 6-7). When Dr. Broudy read a CT scan performed on November 17, 1999, however, he did not observe opacities consistent with simple pneumoconiosis. (EX 18, p. 12). A chest X-ray also taken on that date, which was of film quality 1, revealed to Dr. Broudy scarring in both upper lobes with retraction of the hilar structures. He did not observe any opacities suggesting pneumoconiosis. At that time, Dr. Broudy felt that the abnormalities he observed were due to healed granulomatous disease. (EX 18, pp. 13-14).

On February 12, 2004, the deposition of Dr. Maan Younes was taken by counsel for Claimant. (CX 7, at 1). At the beginning of the deposition, Dr. Younes stated that his B reader license expired in July, 2002, and that he did not take the test to renew the license. (CX 7, at 3). Dr. Younes testified that he examined Claimant on two occasions; the first was on October 20, 1999, for a black lung evaluation, and the second was on December 9, 1999, for an evaluation of a right upper lobe mass. Dr. Younes also reviewed Claimant's medical records for the Department of Labor on January 11, 2000. Dr. Younes confirmed that he also received records of a negative P.P.D. test and a negative histoplasmosis test for Claimant. (CX 7, at 4). Based upon Dr. Younes' examination of Claimant on October 20, 1999, his treatment and consult with Dr. Nadorra in December, 1999, his review of the records on behalf of the Department of Labor on January 11, 2000, and his subsequent review of Claimant's negative P.P.D. and histoplasma tests, Dr. Younes was of the opinion, within a reasonable degree of medical probability and certainty, that Claimant suffers from complicated pneumoconiosis. (CX 7, at 11).

When Dr. Younes saw Claimant on October 20, 1999, Claimant's main complaint was "very significant dyspnea on exertion." According to Dr. Younes, when Claimant walked less than 100 yards, he would become quite short of breath. Claimant also had apnea and had to sleep on two pillows. Dr. Younes performed a complete pulmonary examination that day and found that his lung exam "basically was normal." Dr. Younes also opined that Claimant had normal breath sounds and a normal chest examination. (CX 7, at 5).

Arterial blood gas studies were also conducted, both at rest and with exercise. Based upon the results from the blood gas studies and "especially based on his chest x-ray," Dr. Younes diagnosed complicated coal worker's pneumoconiosis and chronic obstructive pulmonary disease (COPD) based on the pulmonary tests. (CX 7, at 5-6). Dr. Younes explained that, to make a diagnosis of complicated coal worker's pneumoconiosis, large opacities more than one centimeter in diameter must appear on chest X-rays. In diagnosing Claimant, Dr. Younes also took into account that Claimant had a history of coal mine dust exposure from working in the coal mines for over eighteen years. Claimant denied to Dr. Younes that he had any history of smoking cigarettes. (CX 7, at 6, 13). Another factor in his determination of complicated pneumoconiosis was the fact that, when the X-rays taken in February, 1999, were compared with those taken on December 9, 1999, the size of the opacities did not change. According to Dr. Younes, the fact that the opacities were stable was "reassuring of [the opacities] being benign." (CX 7, at 9). Based on these facts, including his interpretation of Claimant's chest X-ray and his coal mine exposure history, Dr. Younes opined that Claimant's pneumoconiosis arose, at least in part, from his coal mine dust exposure. (CX 7, at 6-7, 13-14). As to the diagnosis of chronic obstructive pulmonary disease, Dr. Younes opined that the cause of this disease was also coal dust exposure, based on the fact that Claimant did not smoke cigarettes. Claimant's impairment from the COPD was moderate in nature. (CX 7, at 7).

Dr. Younes testified that when he reviewed additional medical records on behalf of the Department of Labor, and after he consulted with Dr. Nadorra, he still was of the opinion that Claimant was suffering from complicated pneumoconiosis. (CX 7, at 7). According to Dr. Younes, the records he examined showed "no evidence of any exposure to TB. His TB skin test was negative, and no evidence of Histoplasma, so those large opacities, the large opacities cannot be blamed on a previous fungus infection. So, my impression was still the same, no change in my impression." (CX 7, at 7-8). Dr. Younes specifically testified that he has ruled out other possible diseases as causes for the large opacities present in Claimant's X-rays, stating "I don't think it's infection and I don't think it's cancer. And, basically, given his work history and basically the context of everything, I think it's coal worker's pneumoconiosis. (CX 7, at 8). Dr. Younes stated that the opacities present were less likely to be tuberculosis or histoplasmosis because those diseases are more progressive in nature and grow. (CX 7, at 9).

Along these lines, Dr. Younes also discussed Claimant's negative P.P.D. skin test. Dr. Younes testified that if an individual has a negative P.P.D. test, it is more likely that the disease is not tuberculosis. Dr. Younes explained:

> [I]f you have a negative P.P.D. skin test, it shows that your body has not been acquainted with the TB germ. That's what the test tells you, basically. The skin tells you if the body has been acquainted with that germ and you've got some kind of immunity against it or action against it because it's recognized it. So, if the test is negative, that means this germ has not entered your system, and that's what the test means.

(CX 7, at 9-10). Dr. Younes went on to testify that once a person has healed tuberculosis, this would always show up on a skin test because "[o]nce the germ gets into your system, whether you develop symptoms or never develop symptoms, the test shows as positive." (CX 7, at 12).

Dr. Younes could not quote a specific medical article for Employer's counsel, but stated that "this is true evidence fact in textbooks... but I would refer you to all pulmonary and infectious disease textbooks about tuberculosis." (CX 7, at 12-13).

Dr. Younes also explained that an individual can have tuberculosis if they have a negative P.P.D. test:

> Well, that can happen on certain occasions when you have severe overwhelming disease, the immunity of the person is terribly depressed, then you can have TB with a negative test. But that's, like I told you, until a person is very sick, very debilitated, that can happen. But in someone like Mr. Maynard who is ambulatory and fine to have negative TB skin test practically rules out that he had TB.

(CX 7, at 10).

Similarly, Dr. Younes testified that if a person has a negative histoplasmosis test, it is more likely than not that the disease is not histoplasmosis. Further, one can have histoplasmosis with a negative histoplasma test, but that the serum antibodies were negative for histoplasmosis for Claimant. According to Dr. Younes, most of the time when someone has a negative histoplasmosis test, they do not have histoplasmosis. (CX 7, at 10-11). When questioned on cross-examination on this topic, Dr. Younes stated that if the histoplasmosis fungus enters a person's system, the body will make antibodies against it and those would be detected in the histoplasmosis serum. When a blood test is negative for histoplasmosis antibodies, that means that the person has never been exposed to histoplasmosis. (CX 7, at 13).

Deposition of Claimant Sammy Joe Maynard

On November 7, 2001, the deposition of Claimant Sammy Joe Maynard was taken by counsel for Employer. (EX 15, at 1). Claimant testified that he last worked for Employer on June 17, 1985, and at that time had worked for Employer for approximately fifteen years. (EX 15, at 4). While employed by Employer, Claimant performed general inside labor, such as running a motor, hauling coal, and operating a roof bolter. (EX 15, at 4-5). Claimant's job required "quite a bit of lifting and heavy exertion," including lifting rails that were 60 pounds per foot and approximately 20 feet long. (EX 15, at 6, at 25). All of Claimant's work was underground in the coal mines. (EX 15, at 8). Claimant ended his work with Employer on June 17, 1985, when he was injured while running the roof bolt machine. According to Claimant, a piece of rock hit him in the left shoulder and strained his back, shoulder, and legs. (EX 15, at 6). Claimant received worker's compensation benefits for this injury for eight years. (EX 15, at 7).

As to his medical history, Claimant testified that he was currently being treated by Dr. Rosario Nadorra, in South Williamson, Kentucky. Claimant began treating with Dr. Nadorra between six and eight years prior to the deposition, when he became ill with pneumonia for the first time. Claimant has had pneumonia several times since then. (EX 15, at 7-8). When he was ill with pneumonia, he was treated with antibiotics. (EX 15, at 22). Claimant testified that he was never exposed to asbestos that he knew of. (EX 15, at 8). The first doctor that Claimant

could ever recall treating with was Dr. Theodore Cherukuri, in the late 1970s, when he had stomach problems. (EX 15, at 9). Claimant could not recall having many colds as a child, nor could he recall any type of lung problems. (EX 15, at 11-12). Claimant testified that he has never had asthma nor chronic bronchitis. (EX 15, at 21). Claimant began smoking as a teenager, but could not recall when he last smoked. (EX 15, at 12-13). Claimant first had notice of lung problems after Employer sent all of the employees to get examined; he was told to talk to his boss and that he did not need to be working in dust. Claimant related this information to his boss, but his job did not change. (EX 15, at 14-15, 26).

Claimant had his first tuberculosis test sometime after 1985, when he started trying to get compensation and learned that he was not going to be returning to his job. He believed that Dr. Cherukuri administered some of his tuberculosis tests. (EX 15, at 15-16). Claimant testified that he has had at least twenty tuberculosis tests performed upon him, some of which were performed at Williamson Memorial Hospital and at the Pike County Health Department in Belfry, Kentucky. (EX 15, at 19-20). Claimant also stated that he has never had a biopsy performed on his lungs. (EX 15, at 16). Claimant testified that he has never been treated for tuberculosis nor any type of lung disease other than coal workers' pneumoconiosis. (EX 15, at 17). He stated that his doctors, including Drs. Cherukuri, Nadorra, Younes, and Wright, have told him he has a "bad case" of pneumoconiosis. (EX 15, at 18).

As to his work history, Claimant worked as a laborer for a trailer company for approximately five years. As a laborer, he installed trailer hitches on automobiles and hooked utility trailers to them by using a socket and a ratchet to attach the trailers and hitches. He never had to breathe any fumes or particles as part of this process, and no welding was involved in this process. (EX 15, at 10-11). Claimant also worked at gasoline service stations when he was a teenager, and performed such tasks as pumping gas, parking cars, and washing cars. Claimant never installed brakes or worked as a mechanic. (EX 15, at 11).

ARGUMENTS

Claimant's Argument

Claimant argues that pneumoconiosis is recognized as a progressive disease in the current regulations, and, as such, greater weight may be placed on the most recent evidence. (Claimant's Brief, at 6 (citing *Crace v. Kentland–Elkhorn Coal Corp.*, 109 F.3d 1163 (6th Cir. 1997); *Staton v. Norfolk & Western Ry. Co.*, 65 F.3d 55 (6th Cir. 1995); *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993); *Stanford v. Director, OWCP*, 7 BLR 1-541 (1984))). Along these lines, Claimant contends that if a pattern of progression of pneumoconiosis results when X-rays are viewed in sequence, the rational conclusion is that the more recent positive X-rays are entitled to controlling weight. (Claimant's Brief, at 6 (citing *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992))).

Claimant argues that the two most recent X-rays in his case, those taken October 20, 1999, and November 17, 1999, respectively, are more representative of the presence of pneumoconiosis, and more particularly, complicated pneumoconiosis. Claimant asserts that Drs.

Barrett, Younes, and Broudy all read the October 20, 1999, X-ray film as positive for complicated pneumoconiosis. As to the November 17, 1999, X-ray, Claimant asserts that both Drs. Miller and Alexander, who are both B readers and Board certified radiologists, found evidence of complicated pneumoconiosis in that X-ray. To this extent, Claimant argues that Dr. Broudy's negative reading of the November 17, 1999, X-ray should be given less weight since Dr. Broudy read the October 20, 1999, X-ray as positive for complicated pneumoconiosis. Claimant also cites to earlier X-ray readings which found evidence of pneumoconiosis, including Dr. Felson's reading of the May 7, 1987, X-ray; Dr. Spitz's reading of the February 18, 1987, X-ray; and the positive readings by several doctors of the October 26, 1985, X-ray. (Claimant's Brief, at 7).

Claimant maintains that all of the physicians who read his X-rays agree that there is some type of mass in his lungs, but disagree as to whether that mass is complicated pneumoconiosis or some other disease. However, Claimant had both a tuberculosis test and a histoplasmosis test performed, and both tests yielded negative results. While both Drs. Rosenberg and Repsher testified that a negative test for either tuberculosis or histoplasmosis does not necessarily mean that individual does not have that disease, Claimant argues that Dr. Younes' testimony is more persuasive on this subject. Dr. Younes testified that a negative tuberculosis or histoplasmosis test most likely means that an individual does not have either disease, and the scenario described by Drs. Rosenberg and Repsher is typically found only in very debilitated patients, whereas Claimant is ambulatory. Further, Claimant argues that Dr. Younes' testimony is more reliable because Dr. Younes has examined and treated Claimant and reviewed his medical records. Because Dr. Younes is a treating physician, Claimant argues that his opinion is entitled to more weight. (Claimant's Brief, at 8 (citing 20 C.F.R. §718.104(d))).

Finally, Claimant argues that he is entitled to the rebuttable presumption that his pneumoconiosis arose out of his coal mining employment because it was previously established that he worked in the mines for at least 13 1/3 years, and Employer has failed to rebut the presumption. (Claimant's Brief, at 9).

Employer's Argument

Employer argues that a preponderance of the evidence does not support a finding of complicated pneumoconiosis. To support its argument, Employer points to the most recent X-rays and contends that those X-rays were negative for complicated pneumoconiosis, and if Claimant actually had pneumoconiosis, the more recent films would show evidence of such. Employer also cites earlier X-ray readings in which physicians found that diseases other than pneumoconiosis could be the cause of the opacities. Therefore, Employer argues that greater weight should be given to the number of X-ray interpretations that do not diagnose complicated pneumoconiosis. (Employer's Brief, at 30-31 (citing *Edmiston v. F & R Coal Co.*, 14 BLR 1-65 (1990))).

Employer also argues that other medical evidence, namely, reports of examining physicians and the results of several pulmonary function studies, also do not support a finding of complicated pneumoconiosis. Rather, the pulmonary evaluations are "nearly unanimous in their

opinion that the claimant does not have complicated coal workers' pneumoconiosis." (Employer's Brief, at 32-33).

Employer also contends that the medical evaluations of Drs. Younes and Nadorra are skewed and therefore are entitled to less weight. Employer argues that both of these physicians recorded an 18-year coal mining history, whereas the parties have agreed that the actual length of coal mining employment was 13 1/3 years. According to Employer, "[w]hile nearly five years may not seem like a lot, it represents almost a 30% over-estimation of the length of the miner's coal dust exposure. It is proper for the judge to discredit a medical opinion based on an inaccurate length of coal mine employment." (Employer's Brief, at 33 (citing *Worhach v. Director, OWCP*, 17 BLR 1-105 (1993))).

Along these lines, Employer also asserts that Claimant gave several doctors different recitals regarding his smoking history. Employer states that Claimant gave Dr. Broudy two different smoking histories in 1987 and 1999, and that Dr. Rosenberg's review of the records revealed that Claimant had reported his smoking history as anywhere from never having smoked to a thirty pack year history. Employer argues that this inaccuracy also lends itself to diminishing the probativeness of the opinions and the corresponding weight of Drs. Younes and Nadorra. (Employer's Brief, at 33-34 (citing *Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85 (1993); *Goss v. Eastern Assoc. Coal Corp*., 7 BLR 1-400 (1984))).

Employer also indicates that the majority of the doctors reviewing Claimant's medical evidence opined that Claimant does not have complicated pneumoconiosis. Employer cites to Dr. Sargent's deposition testimony, in which he testified that a CT scan "is medically acceptable and relevant to establishing or refuting a diagnosis of coal workers' pneumoconiosis." To this extent, Employer asserts that Drs. Younes, Miller, Alexander, and Barrett did not review the CT scan, whereas Drs. Sargent, Broudy, and Rosenberg did and "were able to confirm that the miner does not have complicated coal workers' pneumoconiosis" but instead that a granulomatous disease was present. (Employer's Brief, at 34-35).

Finally, Employer argues that Claimant has not proven that he is totally disabled due to a respiratory or pulmonary impairment and therefore does not qualify for entitlement to benefits under Section 718.304(c). Employer states that each of the doctors that either examined Claimant or reviewed his medical records agreed that Claimant did not have any pulmonary or respiratory impairment, and that Drs. Repsher, Fino, Rosenberg, and Broudy all agreed that Claimant retained the respiratory and pulmonary ability to return to full time work as an underground coal miner. Because Claimant has not met his burden of proof on this issue, Employer argues that a finding of entitlement is thereby precluded. (Employer's Brief, at 36-37).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The previous Decisions and Orders Awarding Benefits were decided under the version of Part 718 of the regulations that were in effect at that time. However, as a result of the decision in *Nat'l Mining Ass'n v. Chao*, 160 F.Supp. 2d 47 (D.D.C. 2001), the applicable version of Part 718

of the regulations are those which became effective in 2001. Thus, the following discussion will be based upon the standards set forth in 20 C.F.R. Part 718 (2001), and all references to Part 718 will be to the 2001 version of the regulations unless otherwise noted. In order to be entitled to benefits under Part 718, the claimant must establish that he was a miner, that he has pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, that he is totally disabled, and that the pneumoconiosis contributes to the total disability. 20 C.F.R. §725.202(d) (2001).

Based upon the fact that he has established over 13 years of coal mine employment, I previously found that Claimant was entitled to the rebuttable presumption that his pneumoconiosis arose out of his coal mine employment. 20 C.F.R. §718.203(b) (2001). I also found that no evidence was presented to rebut this presumption, and that Claimant established that his pneumoconiosis arose from his coal mine employment. (D&O #2, at 9). The Benefits Review Board affirmed this finding in its Second Decision and Order of Remand. (BRB #2, at 2 fn.2). None of the Board's instructions on remand direct that the issue of whether Claimant has established he has pneumoconiosis, that he worked over 13 years in coal mine employment, or that it arose out of his coal mine employment be revisited. Therefore, the finding that Claimant established that his pneumoconiosis arose from his coal mine employment will not be disturbed on remand. The discussion that follows will focus on reviewing the evidence as instructed by the Board to determine whether Claimant has established that he has complicated pneumoconiosis and thus is entitled to the irrebuttable presumption that he is totally disabled.

Additional Comments by Drs. Kennard, Fisher, Bassali, and Ameji

The Board has directed on remand that the additional comments of Drs. Kennard, Fisher, Bassali, and Ameji made on the X-ray form that may call into question those physicians' diagnoses of complicated pneumoconiosis be considered. The X-ray readings and the comments of each of these physicians will be discussed individually.

Dr. Kennard, a B reader and Board certified radiologist, reviewed the X-ray taken on October 26, 1985. He found that the film was of quality 1, that the opacities were of size q/q with a profusion of 1/0, in the four upper zones. Dr. Kennard also notes that there were large opacities of Category A size, and that Claimant had previous surgery with vascular clips at cardia. (DX 37, p. 14). This is the only X-ray that Dr. Kennard reviewed, and he made no additional comments when reading that X-ray that call into question whether he made a diagnosis of complicated pneumoconiosis. As I noted in the second Decision and Order Awarding Benefits, Dr. Kennard possesses special radiographic qualifications. Based on his qualifications and the fact that Dr. Kennard cited no other potential explanation for the opacities, I find that Dr. Kennard has made a diagnosis of complicated pneumoconiosis.

Dr. Fisher, also a B reader and Board certified radiologist, reviewed the X-ray from October 26, 1985, as well. He also found the X-ray to be of film quality 1. He viewed the opacities as being of size p/t with a profusion of 2/1, in the four upper zones. Dr. Fisher noted Category A size opacities. Additionally, the abbreviations ax, co, hi, and tb were noted. (DX 37, p. 13). This is the only X-ray examined by Dr. Fisher, and there is no record that he ever examined Claimant or any other medical evidence.

While Dr. Fisher holds high radiographic qualifications, it cannot be overlooked that Dr. Fisher offered no additional explanation for checking the box for tuberculosis (tb), nor can it be overlooked that Dr. Fisher has checked "tb" as a *suggestion* of another possible explanation for the opacities. To this extent, the ILO classification chart contains a definition for the additional symbols used when interpreting X-rays. The chart states: "It is to be taken that the definition of such of the Symbols is preceded by an appropriate word or phrase such as 'suspect,' 'pneumoconiotic changes suggestive of,' or 'opacities suggestive of,' etc." As such, even without a physician explicitly using such a phrase preceding his or her finding of tuberculosis, the ILO classification ***presumes*** that such a finding is only suspect or suggestive of pneumoconiotic changes. Therefore, without more evidence to substantiate this type of opinion that an opacity is tuberculosis rather than pneumoconiosis caused by coal mine employment, opinions of tuberculosis are necessarily and by their nature equivocal. As a result, Dr. Fisher's opinion can be credited for, at most, a finding of complicated pneumoconiosis.

Dr. Bassali is a B reader and a Board certified radiologist. The only X-ray Dr. Bassali reviewed was the X-ray taken on October 26, 1985. Dr. Bassali found this X-ray to be of film quality 1. He opined that the X-ray revealed opacities of the size q/t with a profusion of 1/1 in the upper and middle zones. Dr. Bassali also saw Category A large opacities and hence, diagnosed complicated pneumoconiosis. Dr. Bassali's additional comments were: "diffuse chronic interstitial lung disease consistent with pneumoconiosis; distortion of the intrathoracic structures with elevation of both hila; di; tb; rule out active tuberculosis." (DX 37, pp. 7, 8). Similarly, the Board also directed consideration of the additional comments of Dr. Ameji. Dr. Ameji is neither a B reader nor is he a Board certified radiologist. Dr. Ameji read only the October 26, 1985, X-ray. He found that the X-ray was of film quality 1, with opacities size p/t and of profusion 2/1 in 4 zones. He also noted Category A large opacities. Dr. Ameji also checked the boxes labeled "ax", "co", "hi", and "tb." (DX 42, p. 55).

As with Dr. Fisher, neither Dr. Bassali nor Dr. Ameji offers any explanation for checking the box marked "tb" other than to state "rule out active tuberculosis." While the issue of tuberculosis is discussed in more detail below, it is appropriate to note that Claimant underwent both tuberculosis and a histoplasmosis tests in 1999 and 2001, respectively, and the results of both tests were negative. Therefore, without more explanation for his suggestion of tuberculosis, the opinions noting tuberculosis can be considered no more than equivocal. Similar again to Dr. Fisher, Dr. Bassali's and Dr. Ameji's opinions can be credited for, at most, findings of complicated pneumoconiosis.

In summary, I find that the opinion of Dr. Kennard that Claimant has complicated pneumoconiosis is not called into question because Dr. Kennard made no additional comments nor cited alternative suggestions for the opacities. The fact that Drs. Fisher, Bassali, and Ameji opined that Claimant has complicated pneumoconiosis and also suggest other possible causes for the opacities leads me to assign these opinions less weight.

Medical Opinions Diagnosing Tuberculosis or Sarcoidosis

The Board instructed that the medical opinion evidence that diagnosed tuberculosis and/or sarcoidosis but did not diagnose complicated pneumoconiosis was to be considered on remand. A review of the record shows that seventeen different physicians diagnosed either tuberculosis and/or sarcoidosis but did not diagnose complicated pneumoconiosis. Of those seventeen physicians, six offered multiple opinions citing tuberculosis or sarcoidosis as the source of the opacities. However, none of these physicians ever cited additional evidence or explanation to support their suggestion that Claimant had either tuberculosis or sarcoidosis.

Dr. Broudy offered the greatest number of opinions in which he stated that Claimant did not have pneumoconiosis at all, but that the opacities resulted from "possible healed granulomatous disease" such as tuberculosis or histoplasmosis. It should also be noted that Dr. Broudy read one X-ray as being negative for pneumoconiosis, but failed to note any other possible disease. (DX 15). More notable is the fact that Dr. Broudy read one of the more recent X-rays, that taken on October 20, 1999, as positive for pneumoconiosis, with a profusion of 2/3 in four zones, with opacities size r/q. (CX 8). While it is recognized that Dr. Broudy reported this X-ray to be of film quality 3, a total of five different physicians reviewed this X-ray, and only one other physician noted the film quality as anything other than film quality 1 (Dr. Rosenberg noted a film quality of 2). Dr. Broudy testified during his deposition on December 3, 2001, that this X-ray was positive for complicated pneumoconiosis. (EX 18, pp. 6-7).

Dr. Broudy examined Claimant on February 18, 1987. At that time, he noted a 15-year coal mining employment history, a 20-pack year smoking history, and that Claimant had no history of tuberculosis. Despite all of these factors, Dr. Broudy attributed the opacities to "healed inflammatory disease, most likely due to granulomatous disease from tuberculosis or histoplasmosis." (DX 15). Dr. Broudy next examined Claimant on November 17, 1999, when he performed a pulmonary examination and also reviewed other medical evidence. Again, Dr. Broudy noted a lack of history of tuberculosis, but still found that the X-ray showed evidence of healed granulomatous disease. (DX 76, pp. 72-78).

When Dr. Broudy testified by deposition on February 16, 2000, he stated that it is possible for someone to have tuberculosis and not know it, but that if that person had tuberculosis, the germ would remain in the body if no treatment were administered, and that the same rationale would apply to histoplasmosis. (DX 76, pp. 1-30). Dr. Broudy testified on this same subject during a second deposition on December 3, 2001. At that time, Dr. Broudy testified that he had read Claimant's tuberculosis skin test as being negative. However, his testimony changed regarding the results of a negative tuberculosis skin test, as he then testified that a test that may otherwise register as positive may fail to do so if an individual's immune system is not intact. He went on to testify that an individual who once tested positive for tuberculosis may later test negative, as the passage of time can affect the test results. (DX 18, pp. 3-4).

I find that Dr. Broudy's medical opinions are entitled to less weight for two reasons. First, although he is a B reader and a Board certified radiologist, it appears that Dr. Broudy consistently ignored evidence that Claimant had no history of tuberculosis; even when Dr.

Broudy examined Claimant, he made no notations that would suggest that Claimant showed symptoms of tuberculosis. After he read Claimant's 1999 tuberculosis skin test as negative, and after he testified that tuberculosis would remain in the body if no treatment were administered, he attempted to justify his previous findings during his second deposition by insisting that a negative tuberculosis test did not necessarily mean that Claimant did not have or had never had tuberculosis. Dr. Broudy's inconsistent testimony does not contribute to placing great weight on his opinions. To this extent, the ILO chart's definition for the additional symbols used when reading an X-ray states that the finding of another disease is presumed to be only suggestive without additional evidence to substantiate such an opinion, as discussed above. Dr. Broudy offers no such evidence, and this is especially so in light of Claimant's negative tuberculosis skin test. Second, the fact that Dr. Broudy read the October 20, 1999, X-ray as positive for complicated pneumoconiosis, but yet read an X-ray taken less than a month later as negative for the disease, and read another X-ray as negative for pneumoconiosis but failed to cite additional possible explanations for the opacities, also leads to less credibility as to Dr. Broudy's opinions.

Dr. Repsher, a B reader, also provided several diagnoses. Dr. Repsher reviewed six X-rays and consistently found that the X-rays were negative for pneumoconiosis, but suggested emphysema as a possibility as well as "biapical granulomatous disease" such as tuberculosis (with the exception of the X-ray taken on February 18, 1987, which he found to be unreadable). Dr. Repsher also reviewed Claimant's medical records. He noted Claimant's coal mining employment history and his smoking history. Dr. Repsher opined that the CT scan taken on November 17, 1999, by Dr. Broudy documented the lack of simple pneumoconiosis, and it was his opinion that Claimant's X-rays showed "slowly progressive biapical granulomatous disease." (EX 14). Dr. Repsher testified by deposition on November 26, 2001, that when he reviewed Claimant's medical records, he noted that Claimant had tested negative on tuberculosis skin tests. He did go on to testify that his notation of tuberculosis on the X-ray forms was not an actual diagnosis of tuberculosis, but that he made this notation because there was no box to check for biapical granulomatous disease. (EX 17, p. 19). Even taking into account Claimant's negative tuberculosis skin tests, Dr. Repsher opined that it was possible that Claimant had atypical tuberculosis but that the test for that type of tuberculosis was not widely available. Dr. Repsher suggested that nothing short of a biopsy could be done to determine whether an individual actually had a form of tuberculosis or other granulomatous disease, except to take a history to determine whether that person was clinically ill. However, Dr. Repsher went on to state that even a biopsy would not be helpful in Claimant's case in his viewpoint. (EX 17, pp. 15-16, 21). Instead, Dr. Repsher stated that the only true way to know what the lesions were would be to remove part of the upper lobe of the lung, but that this was unnecessary in Claimant's case since he did not have any impairment or disability. (EX 17, p. 17).

At no point did Dr. Repsher examine Claimant. Further, Dr. Repsher rejects anything short of removing a portion of Claimant's lung to determine the cause of the opacities therein. He rejects the more common methods of determining whether a person has tuberculosis, including skin tests, biopsies, and obtaining a clinical history, in favor of the most drastic of all possible investigatory methods. He also discounts the fact that Claimant's clinical history contains no mention of either diagnosis or treatment for tuberculosis, sarcoidosis, or any other granulomatous disease as well as the fact that Claimant's tuberculosis skin tests were negative for the disease. Finally, he offers no further evidence to support his suggestions of tuberculosis

or other granulomatous disease, such as Claimant showing any symptoms of tuberculosis or any history of treatment for tuberculosis. Therefore, I find that Dr. Repsher's opinions are entitled to less weight.

Dr. Sargent read three of Claimant's X-rays. On Claimant's October 26, 1985, X-ray, he found opacities size s/t in the upper and middle lung zones and of profusion 0/1, and noted that they appeared to be like those "of a previous granulomatous disease such as old tuberculosis, histoplasmosis, or even sarcoidosis." (EX 11). However, when examining Claimant's May 7, 1987, X-ray, he noted opacities size t/q in three zones of profusion 1/1. (DX 26). When Dr. Sargent examined Claimant's October 20, 1999, X-ray, he diagnosed pneumoconiosis after finding opacities size s/t in four zones, of profusion 0/1. He additionally noted, "old tb ? old granulomatous disease" and the need for additional studies. (DX 76, p. 100). In a report dated September 12, 2000, Dr. Sargent confirmed his findings and noted that he compared all three of the X-rays that he reviewed. He noted that, in light of the different diagnoses provided, a lung biopsy or computer tomography could be helpful in determining the actual nature of the opacities. (EX 11).

There is no record that Dr. Sargent ever examined Claimant, that he examined Claimant's medical records, particularly those showing that Claimant had negative tuberculosis and histoplasmosis tests, that he had no history of being treated for either of these diseases, or that he had access to Claimant's employment history. Therefore, I find that his report is entitled to limited weight in light of his lack of a complete picture of Claimant's medical and employment history.

Drs. Lane, Vuskovich, and Rosenberg also provided multiple diagnoses of tuberculosis and/or sarcoidosis. Dr. Lane reviewed one X-ray, that taken August 6, 1987, finding opacities of profusion 1/0, size q/p, in the upper four zones, and noting emphysema and tuberculosis. (DX 37, p. 3). He also reviewed Claimant's medical evidence, including his employment and smoking histories, on June 21, 1988, and at that time diagnosed coal workers' pneumoconiosis and "possible tuberculosis or sarcoidosis." (DX 42, pp. 21-23). Similarly, Dr. Vuskovich noted that Claimant's X-ray of April 27, 1991, showed post-active tuberculosis. (DX 45). When Dr. Vuskovich examined Claimant on that same day, and noted his employment, medical, and smoking histories (including Claimant's denial of a history of tuberculosis), Dr. Vuskovich still diagnosed post-active tuberculosis, and further stated that none of Claimant's conditions were related to his coal mine employment. (DX 45).

Dr. Lane's opinion is entitled to little weight, as he only reviewed one X-ray, and only reviewed Claimant's early medical evidence, which occurred in 1988. There is no record the Dr. Lane examined Claimant. Dr. Lane's opinion, therefore, does not cover the 16-plus years since that time, nor any changes in Claimant's condition since that time. Similarly, Dr. Vuskovich's opinion is entitled to little weight because his last review of Claimant's records and his physical examination of Claimant occurred in 1991. His opinion is also entitled to little weight because he completely discounts Claimant's denial of a history of tuberculosis, his negative tuberculosis skin test, and appears to ignore his coal mine employment history.

Finally, Dr. Rosenberg, a B reader, also issued several opinions. Dr. Rosenberg did not note the possibility of tuberculosis on any of the five X-rays that he examined. When questioned about this fact during his deposition, Dr. Rosenberg replied that he did not check the box noting the possibility of tuberculosis because he did not think that Claimant had active tuberculosis. (EX 16, p. 14). When Dr. Rosenberg reviewed Claimant's medical reports, he emphasized that there was a difference in recording findings of abnormalities and interpreting the findings of such. The difference arose, according to Dr. Rosenberg, because when a physician interprets that upper lobe abnormalities have occurred without a background of small nodular opacities, the presence of coal workers' pneumoconiosis is impossible, thereby precluding a finding of complicated pneumoconiosis. Therefore, he opined that the findings were probably an old granulomatous disease. (EX 9). When Dr. Rosenberg was deposed on November 19, 2001, he testified that negative tuberculosis skin tests were not dispositive of whether a person had tuberculosis, because newly diagnosed patients could have negative skin tests. However, Dr. Rosenberg did recommend a biopsy to definitively determine whether Claimant had tuberculosis. (EX 16).

The fact that Dr. Rosenberg reviewed five X-rays without noting on any of the forms the possibility of tuberculosis calls into question when he actually contemplated that Claimant could possibly have tuberculosis. Further, he never examined Claimant, and he discounted Claimant's lack of history of tuberculosis as well as his negative skin tests. Combined with the fact that Dr. Rosenberg is only a B reader, I find that his opinion is entitled to less weight than some of his more qualified colleagues.

Drs. Wright, Jakobson, Halbert, Poulos, Spitz, Scott, Wheeler, Harrison, Abernathy, and Srisumid all offered one opinion diagnosing tuberculosis and/or sarcoidosis but not complicated pneumoconiosis. However, it is to be noted that three doctors, namely, Drs. Wright, Poulos, and Harrison, provided other medical opinions in which they stated that they believed Claimant did have at least simple pneumoconiosis. Dr. Wright found that the October 26, 1985, X-ray showed the possibility of tuberculosis in the left upper zone, and also opacities of profusion 1/0 and size q. (DX 46). However, when Dr. Wright examined Claimant on May 5, 1991, he diagnosed coal workers' pneumoconiosis, after taking into account Claimant's medical and employment history. (DX 46). I find that the latter opinion is the more reliable, in light of the fact that Dr. Wright made that diagnosis with a more complete picture of Claimant and his health situation.

Dr. Poulos examined two X-rays, those taken on December 1, 1986, and May 7, 1987. He noted that the former X-ray showed "probable old granulomatous disease." (DX 51). However, when he reviewed the May 7, 1987, X-ray, he noted a profusion of opacities 1/1 of size q/q, in the four upper zones without any further comment as to the possibility of granulomatous disease. (DX 28). The fact that Dr. Poulos never examined neither Claimant nor his medical records and made these diagnoses based upon two older X-rays leads to less weight being assigned to his opinion.

Dr. Harrison read an X-ray taken on January 19, 1987, as showing small, rounded, and regular opacities. He noted that coal workers' pneumoconiosis could not be ruled out. (DX 16). Dr. Harrison examined Claimant that same day. After taking his medical and employment history, he stated that the opacities may not be due to pneumoconiosis but rather, could be due to

tuberculosis or sarcoidosis, even though Claimant told him that he had had a negative tuberculosis skin test. When Dr. Harrison was deposed on March 17, 1987, he affirmed his diagnosis. At that time, he also stated that he believed Claimant's X-ray was more consistent with granulomatous disease because Claimant was only 40 years old at the time and had worked in the mine only 15 years. (DX 16). As with some of the doctors discussed above, Dr. Harrison discounts Claimant's medical and employment history, and relies too heavily on the fact that Claimant was only 40 years old at the time of his examination. These findings, along with the fact that Dr. Harrison is only a B reader, also leads to less weight being assigned to his opinion.

The remaining eight doctors all read only one X-ray or provided only one medical opinion in which they noted the possibility of tuberculosis or simply granulomatous disease. None of these physicians noted additional reasons for noting the possibility of tuberculosis, and as previously stated, without additional evidence to substantiate such suggestions, opinions of tuberculosis are necessarily and by their nature equivocal. Those opinions are made more equivocal when opinions are given noting the possibility of both pneumoconiosis *and* tuberculosis. Without a more complete picture of Claimant's medical and employment history, these opinions are entitled to little weight.

Dr. Jakobson read the October 26, 1985, X-ray as possibly showing tuberculosis. (DX 42, p. 17). Dr. Halbert reviewed the December 1, 1986, X-ray and noted no pneumoconiosis but noted the possibility of old granulomatous disease. (DX 50). Dr. Spitz read the February 18, 1987, X-ray, noting that it was important to take Claimant's history as to whether he had had tuberculosis and to test for tuberculosis. (DX 42, p. 53). Drs. Scott and Wheeler both read only the April 27, 1991, X-ray, and had similar findings. (DX 47). Dr. Felson read only the May 7, 1987, X-ray, and noted that the Category A large opacities were probably pneumoconiosis, but that he could not rule out sarcoidosis. (DX 37, pp. 18, 19). Dr. Abernathy examined Claimant once, and noted his employment and medical history. Dr. Abernathy diagnosed probable coal workers' pneumoconiosis and possible tuberculosis, which he indicated should be further investigated with sputum examinations. However, Dr. Abernathy also noted that Claimant had no impairment due to coal dust exposure. (DX 21).

Dr. Srisumrid examined two X-rays, those taken on July 10, 1984, and May 14, 1986, and found no evidence of active lung infiltrates or pleural effusion on either X-ray. He did note the presence of a fibrotic scar on the July 10, 1984, X-ray. (DX 14). Dr. Srisumrid also testified by deposition on September 2, 1987, regarding these two chest X-rays. He testified that the fibrotic scar on the 1984 X-ray was not related to pneumoconiosis but rather, was caused by an infection. (DX 36). Dr. Srisumrid cited no additional evidence to substantiate his opinions.

In addition to the findings above, it must also be noted that the Benefits Review Board, in *Cranor v. Peabody Coal Co*., 22 B.L.R. 1-1 (Oct. 29, 1999) (en banc on recon.), held that it was proper for the administrative law judge to consider a physician's X-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." *Id.* at 1-4. In particular, the Board stated that, in that particular case, the interpreting physician's comment that the Category 1 pneumoconiosis found on the chest X-ray was not coal worker's pneumoconiosis did not affect his diagnosis of the disease under Section

718.202(a)(1), "but merely addresses the source of the diagnosed pneumoconiosis." *Id.* at 1-5. That reasoning applies in the instant case as well.

Pulmonary Function and Blood Gas Studies

The Board stated in its second remand of this case that error was committed in considering the pulmonary function and blood gas studies to support the conclusion that Claimant had established complicated pneumoconiosis to the extent that, without accompanying explanation, the evidence was not relevant in establishing the existence of complicated pneumoconiosis. The Board noted that "the evidence is insufficient to demonstrate total respiratory disability pursuant to Sections 718.204(c)(1) and (2) [] inasmuch as none of the pulmonary function or blood gas studies yielded qualifying values." (BRB #2, at 3-4 and fn.5). While consideration of the pulmonary function and blood gas studies and whether those studies provide relevant evidence as to whether Claimant has established the existence complicated pneumoconiosis was not directly ordered by the Board, it is appropriate to clarify the findings as to the pulmonary function and blood gas studies that were made in the second Decision and Order Awarding Benefits in this case. In light of the fact that additional studies have been submitted as evidence in this case, it is also necessary to reexamine the previous findings as well.

I previously found that:

> There are no qualifying pulmonary function studies or arterial blood gas studies, nor is there evidence of cor pulmonale with right-sided congestive heart failure. See §718.204(c)(1-3). There were no physicians who found that the Claimant could not perform his usual coal mine employment from a respiratory standpoint. See §718.204(c)(4). However, §718.304 provides for an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis if x-ray, autopsy, biopsy, or other evidence reveals complicated pneumoconiosis.

(D&O #2, at 9). I went on to find that the record contained a considerable amount of X-ray evidence of Category A lesions in the lung. I also found, as the Board noted, "[T]he Claimant's pulmonary function and arterial blood gas studies, while nonqualifying, show steadily declining values in an individual between the ages of 40 and 45." (D&O #2, at 10). Finally, I concluded that "the *x-ray evidence* is sufficient to establish that the Claimant has complicated pneumoconiosis as permitted under §718.304. It is, therefore, presumed that the Claimant is totally disabled due to pneumoconiosis, and as such, is entitled to black lung benefits." (D&O #2, at 10) (emphasis added).

It appears from the Board's second remand that Employer argued on appeal that the pulmonary function and arterial blood gas studies were relied upon in reaching the conclusion that Claimant established complicated pneumoconiosis. As evidenced by the language quoted above from the second Decision and Order Awarding Benefits, the finding that Claimant established complicated pneumoconiosis was made based upon the considerable amount of X-ray evidence that Claimant has Category A lesions in his lungs. The comments as to the results of the pulmonary function and arterial blood gas studies were merely an observation as to the

values obtained from those studies and were not relied upon in the finding of complicated pneumoconiosis.

Two additional pulmonary function studies, both performed in 1999, have been submitted as evidence since the second decision and order and the Board's second remand. Additionally, two arterial blood gas studies, also both performed in 1999, have been submitted. Therefore, it is appropriate to re-visit the issue of whether these pulmonary function studies and/or the arterial blood gas studies now provide qualifying values.

The pulmonary function study performed on October 20, 1999, yielded a pre-bronchodilator FVC of 3.64, an FEV_1 of 2.65, and an MVV of 101.05. The post-bronchodilator values were: FVC, 3.84; FEV_1, 2.77. A post-bronchodilator MVV was not obtained. There were no additional comments. (DX 76, p. 115). The pulmonary function study performed on November 17, 1999, yielded a pre-bronchodilator FVC of 3.58, an FEV_1 of 2.49, and an MVV of 104. The post-bronchodilator values were: FVC, 3.53; FEV_1, 2.59; and MVV, 109. The comments noted that Claimant gave a "fairly good effort" with "some coughing on MVV." (DX 76, pp. 80-81).

Pursuant to Section 718.204, for a pulmonary function study to be "qualifying," it must yield values that are equal to or less than the appropriate values set forth in Appendix B to Part 718 of the regulations. A "non-qualifying" study yields values that exceed those values. 20 C.F.R. §718.204(b)(2)(i) (2001). In the instant case, neither of the pulmonary function studies performed in late 1999 yielded qualifying results.

The arterial blood gas study performed on October 20, 1999, yielded resting values of 38.8 for pCO_2 and 83.6 for pO_2. The exercise values were pCO_2: 40.0, and pO_2: 84.7. As to the values obtained with exercise, the notes state "Incremental exercise stress test exercised for 00:46 minutes stopped secondary to dyspnea/Bruce protocol." (DX 76, p. 107). The arterial blood gas study performed on November 17, 1999, yielded values of 41.1 for pCO_2 and 95.4 for pO_2. The notes indicate "Normal blood gas on room air." (DX 76, p. 82).

Similar to the pulmonary function studies, for an arterial blood gas study to be "qualifying," it must yield values that are equal to or less than the appropriate values set forth in Appendix C to Part 718 of the regulations. A "non-qualifying" study yields values that exceed those values. 20 C.F.R. §718.204(b)(2)(ii) (2001). In the instant, neither of the arterial blood gas studies yielded qualifying results.

It is also appropriate to note that Dr. Younes did opine, after examining Claimant on October 20, 1999, that Claimant has a moderate obstructive ventilatory impairment and that he does not have the respiratory capacity to perform the work of a coal miner, even though he had administered both pulmonary function and arterial blood gas studies to Claimant which yielded normal values. (DX 76, pp. 102-18). Dr. Younes provided other opinions as to Claimant's condition, but did not again mention Claimant's respiratory capacity or how it might prevent him from performing the work of a coal miner. Dr. Younes was the only physician to ever express the opinion that Claimant was unable to perform his usual coal mine employment from a

respiratory standpoint. I find, therefore, that this evidence is insufficient to establish total disability under Section 718.204(b)(2)(iv).

Complicated Pneumoconiosis

The final issues to be addressed are whether Claimant has established that he suffers from complicated pneumoconiosis and thus whether he is totally disabled. To make these determinations, the relevant evidence must be examined in light of the Board's instruction on remand that the proper weight be assigned to the evidence and the rationale for crediting or discrediting the evidence be discussed.

As a preliminary matter, Employer argues that Dr. Nadorra's notes from February 21, 1992, through September 13, 2001, are not legible. However, in my review of the notes, I found the handwritten notes to be almost entirely legible. Further, Dr. Nadorra's notes were received in this office from Claimant on December 6, 2001, allowing Employer ample opportunity to confer with Claimant regarding the substance of the doctor's notes and/or to take Dr. Nadorra's deposition. Therefore, I will consider Dr. Nadorra's notes as part of the medical evidence of record, and will evaluate and assign its appropriate weight.

In evaluating medical evidence, several principles must be followed. First, as noted by Claimant, recent evidence in black lung cases is particularly important because of the progressive nature of the disease. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Crace v. Kentland–Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997). As stated by the Sixth Circuit in *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993), the "later evidence" rule can be invoked to credit more recent positive medical evidence over earlier negative evidence because of pneumoconiosis' progressive nature. *Id*. at 319. The Sixth Circuit quoted with approval the Fourth Circuit's interpretation of the parameters of this principle:

> In a nutshell, the theory is: (1) pneumoconiosis is a progressive disease; (2) therefore, claimants cannot get better; (3) therefore, a later test or exam is a more reliable indicator of the miner's condition than an earlier one. This logic only holds where the evidence is consistent with premises (1) and (2) -i.e., the evidence, on its face, shows that the miner's condition has worsened. In that situation, it is possible to reconcile the pieces of proof. All may be reliable; they do not necessarily conflict, though they reach different conclusions. All other considerations aside, the later evidence is more likely to show the miner's current condition. On the other hand, if the evidence, taken at face value, shows that the miner has improved, the "reasoning" simply cannot apply. It is impossible to reconcile the evidence. Either the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the earlier. The reliability of irreconcilable items of evidence must therefore be evaluated without reference to their chronological relationship.

Id. (citing *Adkins*, 958 F.2d at 51-52).

As to the issue of numerical superiority, it is within the discretion of the ALJ to rely on the numerical superiority of positive X-ray readings. *Edmiston v. F & R Coal Co.*, 14 BLR 1-65, 1-68 (1990). However, as the Sixth Circuit has stated, the quantity of evidence, alone, cannot be considered without reference to the differences in the qualifications of the physicians, and to neglect to do so is legal error. *Woodward*, 991 F.2d at 321.

Finally, subsequent to the Board's second remand of this case, the Sixth Circuit Court of Appeals held that 20 C.F.R. §718.304 ***is*** properly read as establishing alternative means of establishing invocation of the irrebuttable presumption of total disability due to pneumoconiosis. This is clearly evident in the unambiguous reading and interpretation of Section 718.304 by the Court of Appeals in both *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999), and *Sexton v. Switch Energy Coal Corp.*, 20 Fed. Appx. 325 (6th Cir. 2001) (unpublished). In *Gray*, the Sixth Circuit engaged in an extended discussion regarding the proper reading of Section 718.304 in conjunction with Sections 921 and 923 of the Act. Section 921(c)(3) of the Act states:

> If a miner is suffering or suffered from a chronic dust disease of the lung which (A) when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization, (B) when diagnosed by biopsy or autopsy, yields massive lesions in the lung, or (C) when diagnosis is made by other means, would be a condition which could reasonably be expected to yield results described in clause (A) or (B) if diagnosis had been made in the manner prescribed in clause (A) or (B), then there shall be an irrebuttable presumption that he is totally disabled due to pneumoconiosis or that his death was due to pneumoconiosis, or that at the time of his death he was totally disabled by pneumoconiosis as the case may be.

This is essentially the language in Section 718.304 of the applicable regulations.

> There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, that a miner's death was due to pneumoconiosis or that a miner was totally disabled due to pneumoconiosis at the time of death, if such miner is suffering or suffered from a chronic dust disease of the lung which:
>
> (a) When diagnosed by chest X-ray (see Sec. 718.202 concerning the standards for X-rays and the effect of interpretations of X-rays by physicians) yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C in:
>
> (1) The ILO-U/C International Classification of Radiographs of the Pneumoconioses, 1971, or subsequent revisions thereto; or
>
> (2) The International Classification of the Radiographs of the Pneumoconioses of the International Labour Office, Extended Classification (1968) (which may be referred to as the "ILO Classification (1968)"); or
>
> (3) The Classification of the Pneumoconioses of the Union Internationale Contra Cancer/Cincinnati (1968) (which may be referred to as the "UICC/Cincinnati (1968) Classification"); or

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or

(c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: Provided, however, That any diagnosis made under this paragraph shall accord with acceptable medical procedures.

Finally, Section 923(b) of the Act states, in pertinent part, that:

> [N]o claim for benefits under this part shall be denied solely on the basis of the results of a chest roentgenogram. In determining the validity of claims under this part, *all relevant evidence* shall be considered, including, where relevant, medical tests such as blood gas studies, X-ray examination, electrocardiogram, pulmonary function studies, or physical performance tests, and any medical history, evidence submitted by the claimant's physician, or his wife's affidavits....

30 U.S.C. §923(b) (emphasis added).

The Sixth Circuit plainly stated that, as to Section 921, "We read the disjunctive 'or' in §921 to mean that a miner need not present all three types of evidence in order to qualify for benefits under the Act." *Gray*, 176 F.3d at 389. Similarly, the court in *Sexton* also read Section 718.304 in the disjunctive, finding that a claimant who establishes the existence of a chronic dust disease by either X-ray or biopsy/autopsy results or by other means which would yield the same results as either X-rays or biopsies/autopsies, is entitled to the irrebuttable presumption. *Sexton*, 20 Fed. Appx. at *1. The court went on to state in *Gray* that, "Any of the three types of proof is sufficient, in the absence of other evidence, to invoke the irrebuttable presumption, but none is conclusive if outweighed by contrary evidence. This disjunctive therefore serves to give miners flexibility in proving their claims, but does not establish three separate and independent irrebuttable presumptions." *Gray*, 176 F.3d at 389. Along these lines, the Sixth Circuit also found that irrebuttable presumption found in Section 921 does not preclude an administrative law judge from weighing all relevant evidence. To this extent, the court found that the phrase "all relevant evidence" within Section 923(b) directs the factfinder to weigh evidence from different categories (e.g., X-ray v. autopsy) ***against one another***, not together as the Board suggests, to determine whether a miner suffers from complicated pneumoconiosis. *Id*.

The cases cited by the Board do not precisely address the issue for which they are cited. Particularly, *Mullins Coal Co. of Va. v. Director, OWCP*, 484 U.S. 135 (1987), did not address the issue of the irrebuttable presumption of total disability due to pneumoconiosis. Rather, *Mullins* addressed the issue of weighing all of the X-rays within the record together to determine whether the claimant had established the presence of pneumoconiosis under Section 727.203(a)(1) of the regulations. The Court found that an administrative law judge must not only weigh conflicting interpretations of the same X-ray but also must weigh all of the X-rays to determine whether the claimant has proven the existence of complicated pneumoconiosis. *Id*. at 147-49. The Court did discuss the issue of considering all relevant evidence later in its opinion, but this discussion was with regard to one piece of qualifying evidence being overcome by more reliable conflicting evidence. *Id*. at 150-51.

In *Lester v. Director, OWCP*, 993 F.3d 1143 (4th Cir. 1993), the Fourth Circuit discussed the totality of the evidence. The evidence in *Lester* pitted one X-ray reading of complicated pneumoconiosis against the results of a biopsy test that did not indicate pneumoconiosis and an autopsy which indicated the presence of simple, but not complicated, pneumoconiosis. The record also contained two additional medical reports that refuted the finding of complicated pneumoconiosis. Based on this evidence, the administrative law judge found that the claimant failed to establish the existence of complicated pneumoconiosis, and therefore, was not entitled to the irrebuttable presumption under Section 921(c)(3). *Id*. at 1144-45. The Benefits Review Board affirmed the ALJ's findings, holding that the evidence was properly weighed in determining whether the claimant had established the existence of complicated pneumoconiosis. *Id*. at 1145. The Fourth Circuit affirmed the result reached by the Benefits Review Board. In doing so, the court held that the irrebuttable presumption under Section 921(c)(3) applied only after a claimant proved that he had a complicated pneumoconiosis, which necessarily required, as the Board found, to examine all of the relevant evidence in the record. *Id*.

It is true that in *Melnick v. Consolidation Coal Co*., 16 BLR 1-31 (1991), the Benefits Review Board found that the ALJ must "first evaluate the evidence in each category, and then weigh together the categories at Section 718.304(a), (b) and (c) prior to invocation," and found that the Act required all relevant evidence to be considered. However, the Sixth Circuit's reading and interpretation of the Act and regulations, which requires the evidence under Section 718.304(a), (b), and (c) to be weighed against one another, trumps the Board's interpretation of those same statutory and regulatory sections. Further, this case arises in the Sixth Circuit, and therefore, the interpretations of the Fourth Circuit are at most persuasive, not mandatory, authority. To be sure, the interpretations by the Supreme Court trumps both federal Circuit interpretation and that of the Benefits Review Board. However, in my view and the view of the Sixth Circuit (which did not mention *Mullins*, though was undoubtedly aware of it), the language of *Mullins* does not go to the matter at issue. Therefore, the approach outlined by the Sixth Circuit in *Gray* and *Sexton* will be employed herein to determine whether Claimant has established the existence of complicated pneumoconiosis such that he is totally disabled.

The early X-ray evidence shows some evidence of opacities, including Category A large opacities. In addition to the evidence discussed in the preceding sections, Claimant's October 26, 1985, X-ray was examined by nine physicians. Of these physicians, the six that were both B readers and Board certified radiologists (Drs. Brandon, Cole, Marshall, Mathur, Aycoth, and Deardorff) found at least some evidence of pneumoconiotic opacities and rated the profusion at least 1/0. Five of the six B reader/Board certified radiologist found the profusion to be 1/1 or greater. All noted opacities in multiple zones. As discussed above, Dr. Kennard, also a B reader and Board certified radiologist, found opacities of profusion 1/0, q/q, in four zones, as well as category A large opacities. Dr. Aycoth also noted the presence of category A large opacities. The opinions of these physicians are entitled to greater weight than the opinions from Drs. Anderson and Robinette, and a physician that was identified on the X-ray form simply as "KHA." Dr. Anderson is neither a B reader nor a Board certified Radiologist, and Dr. Robinette is only a B reader. The physician identified as KHA indicates he is a B reader. The special radiographic qualifications held by the six physicians named above entitle their opinions to greater weight.

The December 1, 1986, X-ray was also examined by several physicians. In addition to the opinions by Drs. Broudy, Rosenberg, Poulos, Repsher, and Halbert, discussed above, the X-ray was also read by Drs. Kim and Cooper. Dr. Kim is both a B reader and Board certified radiologist, whereas Dr. Cooper holds neither of those qualifications. While Dr. Kim found no evidence of pneumoconiosis, Dr. Cooper found opacities of profusion 1/2. Given the progressive nature of the disease, it stands to reason that if pneumoconiotic opacities were present on October 26, 1985, they would remain present on December 1, 1986. Therefore, based on my finding that the well-qualified physicians who found pneumoconiotic opacities present in 1985 were entitled to more weight, I find that Dr. Kim's opinion is entitled to less weight. Additionally, Dr. Cooper examined Claimant on December 1, 1986. He took a medical, smoking, and employment history and reviewed Claimant's arterial blood gas and pulmonary function study. He also took into account Claimant's statement that he tested negative for tuberculosis in 1985. Dr. Cooper concluded that Claimant had coal workers' pneumoconiosis. Although Dr. Cooper does not hold qualifications, his opinion is entitled to at least some weight given the fact that he reviewed Claimant's records and medical and employment histories.

Similarly, Dr. Mettu examined one X-ray and performed a physical examination of Claimant. On the May 7, 1987, X-ray, Dr. Mettu found opacities size q/q of profusion 1/1 in the middle and upper lung fields. That same day, Dr. Mettu examined Claimant, took his employment, medical, and smoking histories. Dr. Mettu also considered Claimant's previous negative tuberculosis test. Dr. Mettu's diagnosis was not as specific as Dr. Cooper's, noting only "occupational lung disease due to coal mine employment." Still, Dr. Mettu's opinion is entitled to some weight, despite his lack of qualifications, given that he physically examined Claimant and took into account his histories.

Dr. Wiot examined the August 6, 1987, X-ray. He found opacities of profusion 1/2, size q/t. Dr. Wiot is both a B reader and Board certified radiologist. Based upon his qualifications, I find that his opinion is entitled to greater weight than those physicians who also read this X-ray that do not hold both of these qualifications. Dr. Wiot's opinion is also entitled to greater weight than those physicians who read this X-ray as possibly showing tuberculosis, sarcoidosis, or other granulomatous disease, because they cited no evidence to substantiate their suggestion.

Dr. Fino twice reviewed medical records. The first record review occurred August 10, 1990. Dr. Fino noted that he had not been provided with actual X-ray films but that he would assume that Claimant had simple pneumoconiosis based on the pulmonary and arterial blood gas studies, though he found these studies to be normal. Dr. Fino maintained his opinion when he reviewed Claimant's records for a second time on September 11, 2000. Dr. Fino did not state if X-rays were submitted for him to review in 2000. Because Dr. Fino never examined any X-rays nor physically examined Claimant, I find that his opinion is entitled to less weight.

Dr. Nadorra served as Claimant's treating physician for other unrelated ailments for a number of years, beginning in 1992. Dr. Nadorra's notes indicate that he took an X-ray of Claimant's chest in May, 1992, and found an irregular-shaped density on the left side. Dr. Nadorra was able to monitor Claimant's physical condition through a significant number of examinations conducted between 1992 and 1999. Dr. Nadorra did diagnose complicated

pneumoconiosis. Given that Dr. Nadorra had the opportunity to observe Claimant over a significant period of time as well as the fact that he was knowledgeable as to Claimant's employment and medical histories, I find that Dr. Nadorra's opinion is entitled to some weight, despite Dr. Nadorra's lack of qualifications.

As to the most recent evidence, four of the X-ray readings, those by Drs. Sargent, Rosenberg, Repsher, and Broudy (2 readings) on two most recent X-rays (October 20, 1999, and November 17, 1999), have been discredited as discussed above. The remaining X-ray readings were those by Drs. Barrett, Younes, Alexander, and Miller.

Dr. Alexander examined only one X-ray. On the November 17, 1999, X-ray, Dr. Alexander, a B reader and Board certified radiologist, found evidence of small and irregular opacities p/q, of profusion 1/2. He also found a large opacity 20 mm in diameter in the left upper zone and another opacity measuring 40 mm in the right upper zone, which he stated was consistent with category B complicated pneumoconiosis. (CX 3). While Dr. Alexander examined only one X-ray, I find that his opinion is entitled to more weight. He is duly certified as a both a B reader and Board certified radiologist. He provided a significant of explanation regarding his findings on the X-ray, which were well-reasoned and supported by the evidence. His diagnosis also contains more detail than most of the other X-ray readings present in the record of this case.

Dr. Barrett likewise examined only one X-ray, that taken on October 20, 1999. Therein, he found evidence of p/q size opacities of profusion 1/2 in six zones. He also saw evidence of Category B opacities. (DX 76, p. 94). Dr. Miller examined the November 17, 1999, X-ray, and also found evidence of opacities q/p with a profusion of 1/2, and found these opacities in six zones. He further saw evidence of Category A opacities. (CX 2). While Drs. Barrett and Miller only examined one X-ray each, both are B readers and Board certified radiologists. Therefore, based on their qualifications, their readings are entitled to more weight than other X-rays readings of these same X-rays by doctors who are only B readers and who did not further examine Claimant.

Dr. Younes examined Claimant on October 20, 1999. This examination included a physical examination, as well as consideration of his medical and employment histories, and reading an X-ray taken on that date. Dr. Younes read the X-ray as showing r/q opacities of profusion 2/1 in six zones, including Category A opacities. (DX 76, pp. 102-18). Dr. Younes performed another physical examination of Claimant on December 9, 1999, at which time he noted that his opinion remained unchanged and that he still believed that Claimant had complicated pneumoconiosis. (DX 76, pp. 64-65). Dr. Younes also had the opportunity to review Claimant's medical records on January 11, 2000. Dr. Younes noted that Claimant's X-rays consistently showed a pattern of opacities consistent with complicated pneumoconiosis, and that when compared with the earlier X-rays, the size of the opacities remained stable, indicating that they were benign. Taking into account Claimants coal mine employment history as well as his lack of any history of tuberculosis or sarcoidosis, Dr. Younes reaffirmed his opinion as to his diagnosis of Claimant. (DX 76, p. 67).

When Dr. Younes was deposed on February 12, 2004, he further expounded upon the reasoning behind his diagnosis. He stated that he based his diagnosis on Claimant's coal mine employment history and accompanying dust exposure, the lack of symptoms of infection, and the context of Claimant's history. (CX 7). Dr. Younes further explained the significance of a negative tuberculosis skin test when he stated that the body has not entered the system, the test will be negative, but that if a person had even healed tuberculosis, the skin test would always be positive. He also stated that the only time a person could have a negative skin test and still have the disease is when that person's immune system is very depressed. Dr. Younes testified that Claimant did not fall into this category, based on his examination of him and the fact that he was ambulatory. (CX 7).

While it is noted that Dr. Younes is not currently a B reader, judicial notice is taken of the fact that he was a B reader from 1994 through 2002, which includes the time during which he examined Claimant and his X-rays. Dr. Younes is also in the unique position when compared to the other physicians reading Claimant's X-rays, as Dr. Younes examined Claimant twice, served as one of his treating physicians, consulted with Claimant's other treating physician Dr. Nadorra, and reviewed his medical records (including his negative tuberculosis and histoplasmosis tests). Therefore, the fact that Dr. Younes is not a Board certified radiologist is not outweighed by the fact that he conducted an extensive examination of Claimant, his histories, and his medical records in determining a diagnosis.

Employer argues, as stated above, that Dr. Younes' and Dr. Nadorra's opinions should be assigned less weight because he was given an inaccurate smoking history as well as an inaccurate employment history by Claimant. As to the contention regarding Claimant's coal mine employment history, Employer states that "the parties have agreed that the actual length of coal mining employment was 13 1/3 years." In both the first and second Decision and Order Awarding Benefits, I found that Claimant had been employed by Employer for 13 1/3 years. This finding was made upon considering Claimant's argument that he worked for Employer for 15 1/2 years, as well as copies of W-2 forms submitted by Employer that documented Claimant's employment. For Employer to argue that the parties "agree" to the length of coal mine employment history somewhat misstates the facts as they have presented themselves during the course of this case. Aside from this, I find that the length of coal mine employment history, as stated by Claimant to the physicians who examined him, is not so inaccurate that the medical opinions should be discredited. Claimant initially alleged 15 1/2 years coal mining employment. It is quite possible that when some of the examinations occurred, the phrasing of the question as to length of employment was such that Claimant's time estimate was couched in terms of *when* he began working in the mines, as opposed to the precise length of time spent working in the mines, which could lead to the small discrepancy pointed out by Employer.

As to the argument regarding Claimant's inaccurate statements to Drs. Younes and Nadorra about his smoking history, I find that Dr. Nadorra treated Claimant for a significant length of time such that he any discrepancy as to his smoking history is outweighed by Dr. Nadorra's status as his treating physician. Opinions of treating physicians may be entitled to more weight when such factors as nature and duration of relationship, and frequency and extent of treatment are taken into account. *See* 20 C.F.R. §718.104(d) (2001). As to Dr. Younes, I find that inaccuracy as to the smoking history does impact the proper weight to be assigned to his

opinion. However, Dr. Younes' opinions are otherwise well-reasoned and in line with other medical evidence. Dr. Younes also examined Claimant and his medical records, and despite the fact that Claimant may have reported an inaccurate smoking history to him, certainly he had access to and could have taken into account the smoking histories contained with the medical records he reviewed. Therefore, I find that the impact on Dr. Younes' opinions is slight.

When all of the X-ray evidence is weighed, I find that Claimant has established that he has complicated pneumoconiosis. The X-rays consistently show opacities of Category A size or larger, which is consistent with complicated pneumoconiosis, as diagnosed by several well-qualified physicians. The opacities consistent with complicated pneumoconiosis continue to appear on the most recent X-rays, and given the progressive nature of the disease, the more recent positive X-ray readings are entitled to more weight. The additional medical reports in the record were most often issued in conjunction with reading Claimant's X-rays and in some case, after a review of Claimant's medical records, and also establish that Claimant established that he has complicated pneumoconiosis.

Therefore, I find that the preponderance of X-ray evidence establishes that Claimant has complicated pneumoconiosis as permitted under Section 718.304. Therefore, it is presumed that Claimant is totally disabled due to pneumoconiosis, and as such, is entitled to black lung benefits.

ENTITLEMENT

Pursuant to 20 C.F.R. §725.503, when a claimant proves by a preponderance of the evidence that he is totally disabled due to complicated pneumoconiosis, he is entitled to benefits beginning with the month of onset of total disability. This date is determined from the date of the first diagnosis of complicated pneumoconiosis if complicated pneumoconiosis is established pursuant to 30 U.S.C. §921(c)(3). *Truitt v. North Am. Coal Corp.*, 2 B.L.R. 1-199, 1-203 to 1-204 (1979). The first diagnosis of complicated pneumoconiosis was on October 26, 1985. I find that the evidence within the record is credible to support this finding, especially in light of the fact that the Board affirmed this finding in its second remand decision.

ORDER

Accordingly, it is hereby ordered that Employer, Eastern Coal Company:

1. Pay to Claimant, Sammy Joe Maynard, all federal black lung benefits to which he is entitled, commencing October 26, 1985, as augmented by reason of his dependents: his wife, Irene Maynard, whom he married on May 5, 1965, and his daughter, Clara;

2. Pay to Claimant all medical benefits to which he may be entitled;

3. Reimburse the Secretary of Labor for any payments the Secretary has made to Claimant and to deduct such amounts, as appropriate, from the amount Employer is ordered to pay under paragraphs 1 and 2 above;

4. Pay to the Secretary of Labor interest as provided by law from the date upon which any payment would originally have been due if payment had been made from the date set forth above until the date upon which payment is actually made; and,

5. The benefits paid hereunder shall be offset by virtue of any awards to Claimant for workers' compensation for occupational disease.

6. Claimant's attorney, within 20 days of receipt of this order, shall submit a fully documented fee application, a copy of which shall be sent to opposing counsel, who shall then have ten (10) days to respond with objections thereto.

A

RICHARD E. HUDDLESTON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.